Medicare Statistical Files Manual

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MEDICARE STATISTICAL FILES MANUAL

This manual is prepared by the Office of Statistics and Data Management (OSDM), Bureau of Data Management and Strategy (BDMS), Health Care Financing Administration (HCFA). The purpose of the manual is to provide information about the various statistical files available within HCFA concerning the Medicare program. It is intended to provide enough detail about each file so that persons interested in the Medicare program can determine what data are available. It is not designed for use by computer personnel to write programs or perform detailed systems design.

Most files are annual files subject to limitations such as currency, changes in coding structure, changes in volume, changes in sample size, availability of information, legislative changes and others. The reader should bear in mind that not all files for a given reference period may be available for processing or resources may not be available to process them.

THE INFORMATION IN THESE FILES IS CONFIDENTIAL AND USED FOR ADMINISTRATIVE AND STATISTICAL PURPOSES ONLY. THE RELEASE OF ANY INFORMATION IS SUBJECT TO THE PRIVACY ACT AND OTHER FEDERAL GOVERNMENT RULES AND REGULATIONS.

Further information on the Medicare Statistical Files and data produced can be obtained by contacting the Chief, Data Standards Branch, OSDM, BDMS, HCFA, Room 1-F-2 Oak Meadows Building, 6325 Security Boulevard, Baltimore, Maryland 21207 by mail or by telephone at the following numbers: FTS 934-0942 or (301)-594-0942.

Frank Pirhy

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I. Medicare Data Collection System

Introduction

This Publication describes the various components of the Medicare data collection system. The information collected provides the basis of the statistical system designed to measure the effectiveness of the Medicare program. This system, by manipulating, summarizing, and combining different types of records, produces a wide variety of files and data for use by actuaries, policy analysts, researchers, and management. Knowledge of the benefits available under Medicare and of the way in which Medicare is administered will contribute to an understanding of the Medicare Statistical program. Medicare is administered by the Health Care Financing Administration (HCFA), which also administers Medicaid and other Federal health programs. This new agency was formed in March 1977. Before that, the Social Security Administration (SSA) administered the Medicare program. Many of HCFA's centralized computer operations are still performed by SSA for HCFA.

Basic Provisions of Law

In 1965, amendments to the Social Security Act (Title XVIII) established two complementary health insurance programs for the aged--a hospital insurance (HI) plan (Part A) and a supplementary medical insurance (SMI) plan (Part B). The Part A plan provides coverage for hospitalization, stays in skilled nursing facilities, and home health services. The Part B plan provides coverage for physicians' services, outpatient hospital services, home health services, and other medical services.

Medicare benefit payments under both plans commenced July 1, 1966, except for skilled nursing facilities which began January 1, 1967. These benefits were originally available only to persons aged 65 and over. The 1972 amendments to the Act established coverage for disabled persons under age 65 and for persons with End Stage Renal Disease (ESRD). Their payments began July 1, 1973.

The payment of outpatient hospital benefits is geared to a benefit period (or "spell of illness"). A benefit period begins with the first day (not included in a previous benefit period) the individual is furnished inpatient hospital services and ends after 60 consecutive days during which the beneficiary is neither a hospital inpatient nor a skilled nursing facility inpatient. There is no limit to the number of covered benefit periods the individual may have as long as entitlement to health insurance continues.

The hospital insurance plan (Part A) provides renewable inpatient hospital coverage of up to 90 days for each benefit period. After meeting an inpatient deductible, beneficiaries are entitled to up to 60 days of full coverage and 30 days of coinsured coverage for each benefit period. Each beneficiary also has a lifetime reserve of 60 additional days of hospital care beyond the 90 renewable days allowed for each benefit period. The beneficiary also must pay a coinsurance amount for each of the lifetime reserve days used.

Each beneficiary is provided up to 100 days of care in a certified skilled nursing facility (SNF) for each benefit period but only after a hospital stay of 3 days or more. The insurance covers the costs of the first 20 days of care, and the beneficiary pays a daily coinsurance rate for the remaining 80 days. These benefits started in 1967.

Prior to July 1981, up to 100 home health care visits annually, after discharge from a hospital or skilled nursing facility stay of at least 3 days, were covered under Part A. Effective July 1981, home health coverage under Part A of Medicare provides for unlimited visits, and the 3-day prior stay requirement was eliminated.

The SMI plan (Part B) covers such items as: physician services, diagnostic X-ray and laboratory tests, radium therapy, ambulance services, surgical dressings, other medical needs, and prior to July 1981 up to 100 home health care visits each year. Effective July 1981, unlimited home health visits are permitted but are considered Part B services only if the beneficiary does not have Part A coverage.

Generally, after a beneficiary pays an annual deductible, medical insurance will pay 80 percent of the reasonable charges for covered services for that year. For some services, however, Medicare will pay 100 percent of covered reasonable charges; e.g. services performed in an independent laboratory that are billed on an assignment basis are reimbursed at 100 percent of a negotiated rate not subject to any deductible or coinsurance.

Prospective Payment

Effective October 1, 1983, Medicare implemented a prospective payment system for reimbursing inpatient hospital operating costs. This system replaced the existing retrospective cost reimbursement system whereby interim rates were paid on each bill and end of year adjustments were made based on information contained in hospital cost reports. Hospitals are now reimbursed a fixed amount, determined in advance, for each case according to one of 473 Diagnosis Related Groups (DRG's). A discharge is assigned to a DRG based on diagnosis, surgery, patient age, discharge destination, and sex. Each DRG has a weight established for it based primarily on Medicare billing and cost data. Each weight reflects the relative cost, across all hospitals, of treating cases classified in that DRG.

Additional payments are made for hospital discharges meeting specified criteria as "outliers", for pass through costs, and for disproportionate share hospital costs. Outliers are cases that have an extremely long length of stay or unusually high costs when compared to most discharges classified in the same DRG. Pass through cost payments are made for direct and indirect costs of medical education, capital, bad debts, and existing acquisition costs. Disproportionate share hospitals are those having a low income patient load exceeding a threshold amount based on bedsize and urban or rural location.

Prospective payment applies to all Medicare-participating hospitals except psychiatric, long term, childrens, and cancer treatment hospitals. Also excluded are distinct part rehabilitation, psychiatric, skilled nursing care, and alcoholic treatment units of acute care hospitals. Four States received waiver because they had, in place, all payer prospective payment systems. They were Maryland, Massachusetts, New Jersey, and New York. Effective with each hospital's 1986 fiscal year, hospitals in Massachusetts and New York are paid under PPS; Maryland and New Jersey have retained their waivers.

Fiscal Intermediaries

Under the HI program, fiscal intermediaries (FI's) are selected by each institutional provider (hospitals, skilled nursing facilities, home health agencies) to act as the link between the provider and the Health Care Financing Administration. A vital role of the intermediaries is to review and pay claims for the cost of providing care to the beneficiaries. The intermediary makes these payments to providers for covered items and services and assists in the application of safeguards against unnecessary use of covered services.

For institutional providers not on prospective payment, the reimbursement amount shown on the billing records is an interim payment based on estimates of actual costs. Each institution is required to prepare a cost report at the end of its fiscal year and final reimbursement is made on the basis of this report. These cost reports are professionally reviewed and audited as necessary by the FI. Portions of the cost reports are transmitted to HCFA to be used in rate setting and policy development.

For hospitals on prospective payment, the diagnostic, surgical, and other pertinent information shown on the billing forms are edited and then processed through a computer program called GROUPER to assign the DRG. If there are problems with the codes, the FI resolves them with the hospital. Once the DRG is assigned, the bill is processed through other operations to determine the price Medicare will pay. Hospitals on prospective payment are also required to file cost reports.

Carriers

Under the SMI program, carriers are selected by the Secretary of Health and Human Services. The principal functions of these carriers are to determine the reasonable charges in their respective areas for each medical care service paid for under the program and to review and pay claims to or on behalf of beneficiaries for the services provided. They also maintain customary and prevailing charge profiles of physicians in their geographic area.

Social Security Administration

The Social Security Administration (SSA) maintains demographic and entitlement information on all OASI, Disabled, and ESRD beneficiaries. The Health Insurance Master (HIM) file is updated daily for current maintenance and utilization information. Maintenance data consist of beneficiary enrollments and terminations, cross-reference of claim numbers, changes of address, and other changes which are received from the SSA and the Railroad Retirement Board master beneficiary record (MBR) systems. Utilization data consist of: notices of hospital admissions, SNF admissions, Part B deductible queries, provider billing records from intermediaries, and payment records from carriers. Both the utilization and maintenance data are matched to the HIM for updating as part of HCFA's administrative processes.

Hospital Insurance Claims Process

The HCFA Central Office HI Claims process operation is essential to provide current benefit and utilization information to intermediaries. It also monitors intermediary payment to institutional providers. When a beneficiary is discharged, the participating

provider submits a bill to the intermediary. The intermediary then transmits the information as a query to HCFA to check the beneficiary's status and validate entitlement, deductible, and coinsurance information on the bill. Based on the information furnished by HCFA, the intermediary certifies payment to the provider. The intermediary then forwards the bill to HCFA for processing through HCFA's administrative operations.

Consistency Editing

This operation balances the number of bills and reimbursement amounts to the intermediary's total to establish acceptable tape totals for use through the remainder of the automated processing. A computer edit program identifies all invalid data and inconsistencies for each bill. Invalid data include such items as a month indicated by a number greater than 12, more than 60 lifetime reserve days used, and so forth. The DRG on prospective payment hospital bills is also edited.

The consistency edits do not compare data on the bills to information in HCFA records. These edits are used as a screen to check the consistency of data on the bill itself.

Utilization Editing

Once the consistency edits have been applied, the bills go through the utilization editing program. In this program, the bill data on the tape are compared to the data in HCFA's Health Insurance Master Record.

The bills in the batch which failed the consistency edits are screened in the utilization program for only three items:

1. name and claim number which match the master record,
2. eligibility to Part A or Part B benefits during the billing period, and
3. a matching open item on HCFA's Health Insurance Master Record. "Open" items are created from admission notices and are "Closed" by discharge bills or deletion queries.

Bills which have passed the consistency edits are processed completely through the utilization editing program and are either posted or rejected. The detailed edits resulting in a potential 300 distinct error conditions are described in Section 3830 of the Part A Intermediary Manual. This manual is maintained by the Bureau of Program Operations, HCFA.

Rejected bills are returned to intermediaries for correction and reinstatement (or voiding). Both bills and batches are held in the control system until their processing is completed or until they are deleted. Reports of batch processing, batch completion, and outstanding returned bills are periodically sent to intermediaries to use in reconciling batches submitted and in checking on bills to be corrected and returned to HCFA. Records of the bills passing initial edits are passed on to the Beneficiary Master Update operation; which records the transactions on the individual's HI Master record, and generates records for updating the provider Master File; and to a history record of completed billing transactions. The update operation will also generate a beneficiary utilization notice where an interim or a final (discharge) bill is processed for inpatient services or home health visits.

Part A inpatient bill information is processed on an "in sequence" basis. This sequence is determined from the billing dates "from" and "to" present on each bill. Bills are processed in "from" date sequence within a benefit period.

Medical Insurance Claims Process

Part B outpatient bills and Part B home health agency bills are submitted from intermediaries, while Payment Records covering physician, supplier, and ambulatory surgical center services are submitted from carriers. The processing procedure differs from that for Part A bill records because, unlike Part A, Part B benefits are not tied to a benefit period with a limited number of days of care and varying coinsurance amounts. Under Part B, only physical therapy and psychiatric services have an annua limitation on benefits payable.

Claims for payment of Part B benefits are submitted to the carrier or intermediary by beneficiaries or the supplier of services (such as physicians). When the carrier or intermediary queries HCFA on the beneficiary's deductible status, the utilization query/reply operation handles the transaction similarly to Part A queries.

In addition, Part B queries update the Part B deductible and record physical therapy and psychiatric expenses. The carrier or intermediary determines and makes payment to the claimant, taking into account the beneficiary's deductible status.

Carriers submit Payment Records for all physician and supplier claims for which payment is made. These Payment Records are batched and transmitted to HCFA where they are edited and then matched against the HI Master Record to check for beneficiary entitlement and, if appropriate, to record physical therapy or psychiatric services. A listing of rejected records is returned to carriers for corrections and the records are held in a suspended record file. As records are corrected and returned, they are deleted from this file. In addition, another operation controls the batches of Payment Records and provides statistical reports on bill processing by each carrier.

The Explanation of Medicare Benefits (EOMB) is an important function of the carriers and is used to notify each claimant for Part B benefits of the action taken on his claim. Section 7000 of the Medicare Carrier's Manual provides an in-depth description of the purpose and contents of the EOMB. This manual is maintained by the Bureau of Program Operations, HCFA.

Carriers send HCFA monthly reports of amounts paid during the month for SMI services. Batches of Payment Records are matched against these carrier financial reports to determine if submitted records of payments by carriers balance HCFA's reimbursement to them for Part B payment made. HCFA then reconciles any differences.

HCFA does not receive bills for Part B services rendered by certain Group Practice Prepayment Plans (GPPP's) and Health Maintenance Organizations (HMO's). These groups deal directly with HCFA and are reimbursed on a per capita cost basis.

Provider Of Service Master File

Institutional providers of services (hospitals, SNF's, and HHA's) participate in the Medicare and Medicaid programs through a formal certification procedure which examines the institution's qualifications for furnishing care for the beneficiaries of the two programs. The certification is done by State agencies according to HCFA guidelines and regulations. The qualifications are reviewed periodically, following the same procedure.

The State agency surveyor applies various criteria to measure an institution's capability of providing acceptable care. At the same time, provider characteristics such as staffing, number of beds, and services provided are recorded on a forms package. This forms package is divided into two sets. The first set, called the Survey Report Form (SRF), contains the criteria and the decisions of a surveyor in applying the criteria to the institution being evaluated. For example, the surveyor evaluates such areas as staffing, physical environment, medical records, nursing, and dietary departments in hospitals and nursing homes. The second set comprises the source documents for the Provider of Service (POS) master file, and includes the Certification and Transmittal Form (C&T) and the application form. The C&T Form records address information, intermediary tie-in, and the certification decisions and certification approval dates of the State agency and the HCFA regional office. The application form contains the provider characteristics (type, control, staff, services, etc.).

When the on-site survey by the State agency surveyor has been completed, it is reviewed and approved by the State agency and forwarded to the HCFA regional office for review and final certification by the regional office. The reviewer ascertains that all forms are present and properly prepared. The data items that are prescribed for entry into the data base are then keyed to magnetic disk. The first group of consistency checks are applied as the data are entered. Incorrect entries alert the operator via a Cathode Ray Tube (CRT) display screen and for certain fields prevent further entry of the forms package in question until corrections are made. Those forms packages successfully keyed to the disk are batched daily in the regional office and transmitted via telephone lines to central office. A transaction record is built in central office by combining all the POS and SRF data elements into a single record for each provider of service. This record is next passed through a more extensive series of consistency checks for accuracy and completeness. The fully edited record is then entered into the provider of service master file.

The Medicare Decision Support System

The primary objective of the Medicare Statistical System (MSS) is to provide data required to measure and evaluate the operation and effectiveness of the Medicare program and to provide data for pre-decision support. The benefit payment operations furnish the means of obtaining extensive, systematic, and continuous information about the amount and kind of hospital and medical care services used by Medicare beneficiaries, as well as the costs of such services. The applications submitted by hospitals, skilled nursing facilities, and home health agencies to participate in the Medicare program provide data on the characteristics of such providers of services. The claim number that is assigned to each beneficiary serves as the link between the various services used under the program and the demographic characteristics of each individual recorded in the enrollment files.

The data-collection system has two inherent characteristics that greatly determine the scope, detail, and flexibility of the available data. First, data are collected and maintained on an individual basis so that the beneficiary and his medical experience under the program form the basic unit. Second, records for each bill paid are maintained on a centralized basis. Except for intermediary operating statistics such as those relating to workloads, time lags, and costs, all program statistics are centrally prepared.

The statistical system is based on five basic record groups which are byproducts of the Health Insurance Administrative operations. The record groups are described below.

- The Health Insurance Master Enrollment Record - This record identifies each person (aged and disabled) enrolled for Medicare. Data describing the characteristics of the Medicare enrolled population are obtained from this file. This file also serves as the basis for obtaining Medicare utilization rates. Approximately 28 million aged beneficiaries and 3 million disabled beneficiaries are currently entitled to Medicare benefits.

- The Provider of Service Record - This file contains information on every hospital, skilled nursing facility, home health agency, independent laboratory, and other institutional provider which must apply for participation in the program. Each is assigned a distinct provider number. Approximately 6,700 hospitals, 6,100 SNF's, 5,200 HHA's, 3,900 independent laboratories, and 1,600 other types of facilities that participate in Medicare are on this file.

- The Utilization Record - Part A and Part B billing information is maintained centrally; and these records are tabulated monthly, quarterly, and annually to measure the use of Medicare services. While the annual volume of Medicare bills processed will vary from year to year, the approximate number processed in any year is as follows:

Inpatient hospital	11,000,000
SNF	800,000
Outpatient	29,000,000
HHA (A and B)	5,000,000
Payment Records (physicians and suppliers)	200,000,000

- The Provider Cost Report Record - This record includes provider fiscal periods which are necessary to rate setting and to policy development. Cost data are captured on institutional providers; i.e., hospitals, SNF's, HHA's, and ESRD facilities.

- The Special Program Data - Data are collected specific to special programs within Medicare; e.g., ESRD and, as necessary, for the purpose of research, demonstrations, and policy analyses; e.g., SSI days for disproportionate share hospitals.

Since each utilization record contains both the beneficiary's claim number and the provider's Medicare identification number, these records can be matched to the Enrollment and Provider records. By this process we create statistical records that contain the information needed for tabulations from the three files.

The billing information reported includes days of care, detailed ancillary charges, Medicare reimbursement amounts, discharge status, diagnostic and surgical information. By mid-1985, all institutional providers were reporting on the HCFA 1450 (uniform bill) billing form.

Prior to October 1983, the diagnostic and surgical information was reported in narrative form (up to 45 characters for diagnosis and 41 characters for surgery) for samples of

bills only. Only one diagnosis and surgical procedure (if any) was coded. The coding system in use since 1979 is ICD-9-CM, Volumes I and II, for diagnosis and ICD-9-CM, Volume III, for surgical procedures. For services before 1971, ICDA-7 was used; and from 1971 - 1978, it was ICDA-8.

In October 1983, hospitals were required to report only ICD-9-CM codes for inpatient hospital bills. Narratives were no longer permitted. Inpatient hospital bills were to contain codes for the principal diagnosis and up to four additional diagnoses and principal surgical procedure and up to two additional surgical procedures, if any. Inpatient hospital bills also were required to contain a Diagnosis Related Group (DRG) number to determine reimbursement for prospective payment. The DRG is assigned by the fiscal intermediary by processing the billing information through a computer program called GROUPER.

Medicare bills other than inpatient hospital, outpatient, home health, and skilled nursing facility were still reporting either narratives or codes until April 1985 when only ICD-9-CM codes were permitted.

MAJOR MEDICARE STATISTICAL FILES BY DATA CATEGORY

Most Medicare statistical files are summarized on a calendar-year basis by the year the service was incurred. The files contain varying amounts of detail on charges, days of care, Medicare reimbursement, beneficiary characteristics, and provider characteristics. In addition to the files, an ongoing series of detailed tabulations are prepared containing data on enrollment, bills, charges, days of care, and reimbursements by type of Medicare benefit nationally, by State, and some, even by county of residence.

A. Utilization - Institutional Providers

1. Medicare Provider Analysis and Review (MEDPAR)

   An annual file of hospital discharges containing detailed accommodation and departmental charge data, days of care, diagnostic/surgical information, and beneficiary demographics. The file size was increased to 100 percent on October 1, 1983. Previously, MEDPAR was for a 20 percent sample of beneficiaries.

2. Provider Summary Record - 100 Percent

   This file contains current and prior-year summary utilization information by Medicare certified hospital, including number of bills, days of care, charges, and reimbursement. This file is primarily used for Admission Pattern monitoring and Prospective Payment System monitoring.

3. Annual Home Health Agency Bill File - 40 Percent Sample

   Contains HHA billing data and beneficiary characteristics.

4. Annual Outpatient Bill File - 5 Percent Sample

   Contains outpatient billing information and beneficiary characteristics.

5. Skilled Nursing Facility Stay Record File - 100 Percent

An annual file of admissions with billing information, admitting diagnosis, and beneficiary characteristics.

B. Part B Data - Physicians Ambulatory Surgical Centers and Suppliers

Part B Medicare Annual Data Files (BMAD)

The Part B data are provided in four separate files; carriers extract the data annually from their claims processing history files.

1. Procedure File - Provides an array of every procedure processed showing the related frequency, submitted charge, and paid amount. This gives HCFA detail on the services processed by carriers.

2. Prevailing Charge File - Provides HCFA with the prevailing charge limits for each service contained in the Procedure File. This allows HCFA to study and accurately project payment levels. It is currently being used to establish clinical lab fee payment schedules.

3 Provider File - Contains line-by-line detail from claims history of procedures rendered by a 1 percent sample of physician/suppliers. This allows HCFA to study the impact of actual and projected program changes on them. It also allows HCFA to conduct longitudinal analysis of practice trends. This sample is increased to 5 percent for 1985.

4. Beneficiary File - Contains line-by-line detail from claims history of services received for a 5 percent sample of aged and disabled beneficiaries and all ESRD beneficiaries. This allows HCFA to link, based upon the beneficiary health insurance claim number, a beneficiary's Part B service utilization data with the Part A service utilization data that exists in other CO files.

C. Longitudinal Utilization and Beneficiary Data

1. Continuous Medicare History Sample - 5 Percent Sample

A summary file which links data covering all Medicare benefits on a 5 percent sample of beneficiaries' characteristics on a continuous annual basis. Beneficiary characteristics and data on each hospital and SNF stay along with diagnostic and surgical information is included. The file can be used as a longitudinal statistical data base to study beneficiary utilization of all Medicare benefits.

2. Medicare Automated Data Retrieval System (MADRS)

MADRS is designed to reorganize the massive 100 percent Bill and Payment Record File to index them so that it will be easier and less expensive to retrieve data for research and demonstration purposes.

MADRS will contain 100 percent of hospital bills, outpatient bills, skilled nursing facility bills, home health bills, and physician and supplier payment

records. Often claims records files are separated into Part A and Part B depending on which Medicare insurance program covers them; MADRS will contain both types of claims. The more important data elements available in these claims are patient health insurance number, provider number, HMO enrollment, reason for entitlement, dates of service, types of services, diagnosis, charges, reimbursed amounts, and coinsurance and deductibles.

MADRS is in the implementation phase.

D. Financial Data

1. Hospital Cost Report Information System (HCRIS)

HCRIS is an automated data collection, processing, and report generation system that contains hospital-specific financial and statistical cost report data from Medicare certified hospitals and hospital/health care facility complexes beginning with hospital fiscal years ending on or after January, 1, 1982. HCRIS also contains Title V and/or Title XIX data when the hospital is reimbursed under the program(s) on a reasonable-cost basis and the Medicare Fiscal Intermediaries (FI's) are responsible for processing and setting their cost reports.

2. Section 223 Cost Limit File for SNF's and HHA's

This file contains data abstracted from cost reports submitted by SNF's and HHA's. The file is processed to develop the limits on Medicare payments to these institutions, as mandated by Congress.

E. Institutional Provider Identification and Certification

1. Provider of Services

As a by-product of the Medicare/Medicaid Provider certification process (MMACS), data which identifies and characterizes the participating institutional providers (hospitals, HHA's, etc.) are collected through the regions and recorded centrally in a continually updated data base. The data are used both administratively by HCFA and/or the PRO's and for many statistical reports. Additionally, the POS data are appended to the billing records to enable tabulation of utilization by provider characteristics, as necessary.

2. Provider Specific File

The Provider Specific File is a component of the PRICER program used in the FI's systems to compute individual DRG payments. It is needed in central office to supply essential data elements in the PPS recalibration processes and related PPS activities. The FI's have been instructed in a manual issuance to submit the history of Provider Specific records at the end of each calendar quarter.

F. Beneficiary Entitlement and Demographics

Health Insurance Skeleton Write-off (HISKEW) - 100 Percent

This file contains selected beneficiary entitlement and demographic information from the Health Insurance Master File such as age, sex, race, State, County, ZIP-Code, and entitlement. It is used to prepare an ongoing series of enrollment tabulations detailing the number and characteristics of Medicare beneficiaries, e.g., 1984 enrollment is prepared from the March 1985 HISKEW.

G. ESRD Program Data

End-Stage Renal Disease Program Management and Medical Information System (ESRD PMMIS)

The ESRD PMMIS is a uniform data base of national scope which contains basic medical and program management data elements related to the services provided by Medicare-approved ESRD facilities in the treatment of dialysis and kidney transplant patients:

The ESRD PMMIS is a comprehensive patient-based system which includes, by patient:

1. identifying characteristics,
2. primary disease,
3. first date of ESRD care,
4. incidence records on dialysis and transplantation,
5. incidence of hospitalization and outpatient care, and
6. date and cause of death,

and an all inclusive facility-based system which includes, by Medicare-approved ESRD provider:

1. identification and certification characteristics, and
2. aggregate treatment surveys.

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Further information on the Medicare Statistical Files and data produced can be obtained by contacting the Chief, Data Standards Branch, OSDM, BDMS, HCFA, Room 1-F-2 Oak Meadows Building, 6325 Security Boulevard, Baltimore, Maryland 21207.

II. Enrollment

Introduction

This chapter describes the files used to obtain data on the total Medicare population and also various subpopulations of persons enrolled for Medicare benefits.

The Health Insurance Master File (HIM)

The Health Insurance Master File (HIM) identifies each person entitled to Medicare benefits. Entitlement may be for aged, disabled, or end stage renal disease whether a person is covered for hospital insurance benefits, supplementary insurance benefits, or both. Data on age, sex, race, and place of residence are obtained from this file.

For each person eligible for Medicare benefits, a record is maintained in the HIM file. Identification of each record is based on a claim number which consists of a person's Social Security or Railroad Retirement Board number and a one or two position beneficiary identification code (BIC). The BIC portion of the claim number describes the type of benefit that entitles individuals to Medicare coverage. The most common BIC's are "A" for a primary wage earner, "B" for a wife age 65 or older, and "D" for a widow age 65 or older.

The HIM file is updated daily for current maintenance and utilization information. Maintenance data consist of beneficiary enrollments and terminations, cross-references, changes of address, and field changes which are received from the Master Beneficiary Record system of SSA and the Railroad Retirement Board. Utilization data consist of notices of hospital admission, queries, provider billing records, and payment records received from intermediaries and carriers. Both the utilization and maintenance data are matched to the HIM for updating as part of HCFA's administrative process. This is illustrated in Exhibit A.

Health Insurance Skeleton Eligibility Write-off File

To tabulate enrollment data, a skeletonized version of the HIM file, known as the Health Insurance Skeleton Eligibility Write-off (HISKEW), is created. The HISKEW file is produced quarterly from the HIM file.

A record format of this file, which includes a description of each field, is shown in Exhibit B. Approximately fifty million HISKEW records are created each quarterly processing period. This includes twenty million inactive (deaths) records.

Annual Enrollment Publication Tables

The annual enrollment tabulations showing the number of persons enrolled as of July 1 and the number of persons enrolled at any time in the year are produced from the HISKEW file created as of March of the following year. For example, 1985 data are produced from the March 1986 HISKEW file.

The tabulations contain counts of aged, disabled, and end stage renal disease enrollees by:

1. Type of coverage (HI, SMI, or both).

2. Age, race, and sex.

3. State of residence at time file is created.

4. Residence in Metropolitan Statistical Areas and Metropolitan and Non-Metropolitan counties.

5. Number of persons newly enrolled or terminated during the year of the data.

In addition to the above, enrollees by county are shown as part of a tabulation containing enrollment and Medicare reimbursement by State and county. Annual and quarterly data are tabulated and used for text tables, control tables, and utilization rates but are not routinely published.

Special Population Groups

1. Railroad Retirement Board (RRB) - A file of RRB beneficiaries entitled to Part A and/or Part B coverage is developed each year from the March HISKEW file. Enrollees are selected from this file based on RRB claim numbers. The entire HISKEW record is retained for each person selected. The file is used to obtain control data and can also be used to select records to study utilization of RRB enrollees.

2. State Buy-In Enrollment - A State, through a buy-in agreement with HCFA, may enroll needy aged and disabled persons eligible for either public assistance or medical assistance programs for Part B coverage. Once buy-in eligibility in these programs is established, enrollment of an individual is involuntary on the part of the person even though he does not wish to enroll or has enrolled individually for Part B coverage; neither can he voluntarily terminate this coverage. A record for each enrollee is maintained in the HCFA Third Party Master file.

   This file is updated from records submitted by the State to HCFA of individuals to be added to or deleted from its coverage group. Those records to be added to the group are screened against the HIM file to determine if the person is eligible for Part B benefits. Matched records are annotated to indicate buy-in status in the HIM file, added to the Third Party Master file, and billing to the State is initiated.

   Each year a State buy-in membership "ever enrolled" file population is developed from the Third Party Master File. Records are selected for this file if a person is a buy-in at any time in the specified calendar year. For each person selected, a record is created containing the following information:

   a. HI claim number

   b. Date of birth

   c. Sex

   d. Race

   e. State of residence at time file is created

f. Cross-reference claim number

g. Buy-in plan start date

h. Termination date

The file is summarized by age, race, sex, and State of residence. Tables are prepared presenting these data based on the number of buy-ins enrolled at any time in a year and as of July 1 of each year.

3. Group Practice Prepayment Plans (GPPP's) and Health Maintenance Organizations (HMO's) - The Group Health Plan System (GHP) maintains a membership file for those GPPP's and HMO's that deal directly with HCFA for purposes of reimbursement and to control posting of deductible pro-rata amounts of each plan member entitled to Part B coverage. One-twelfth of the Part B deductible is allotted to each member each month. Reimbursement to each plan for Part B services rendered to members is on a cost basis for GPPP's dealing directly with HCFA. A file of enrollees by plan is maintained by HCFA and is called the Health Insurance Control Group Health Plan Master file (HCGPMSTER). The HCGPMSTER file is updated by records submitted to HCFA by a GPPP. Each record is screened for Part B eligibility against the HIM file and processed to the HCGPMSTER file.

Annual enrollment data are developed only for those plans dealing directly with HCFA. Records are selected from the HCGPMSTER file containing the following information:

a. HI claim number

b. Date of birth

c. Sex

d. Race

e. State of residence at time file is created

f. Cross-reference claim number

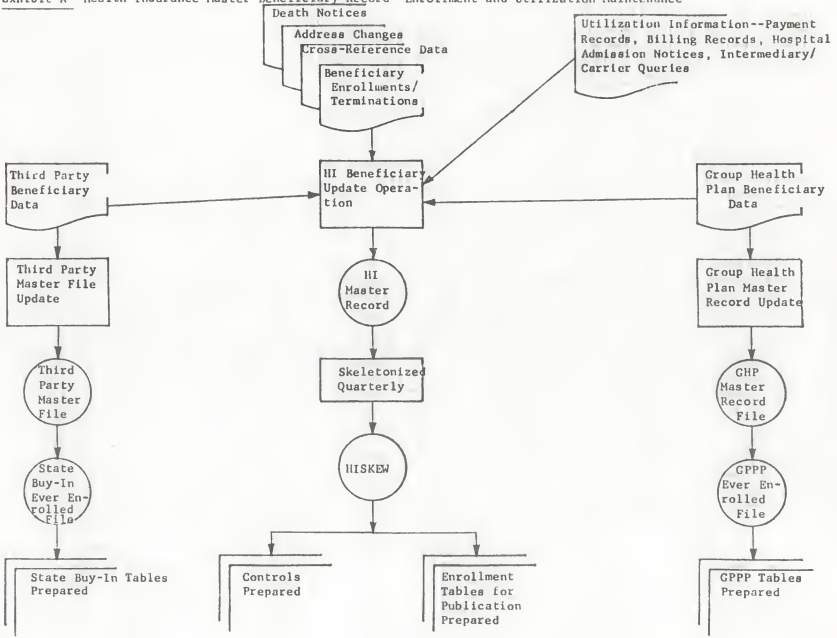
g. Plan start date

h. Termination date

i. GPPP or HMO plan number

This information is summarized by age, race, sex, GPPP or HMO plan, and State of residence. Tables are prepared presenting data on the number of persons enrolled at any time in a year and as of July 1 of each year.

Exhibit A--Health Insurance Master Beneficiary Record--Enrollment and Utilization Maintenance



HISKEW Record Contents

	Information	Description
1.	HI Claim Number	Beneficiary's health insurance claim number.
2.	Date of Birth	Julian date of beneficiary's birth.
3.	Sex	-Male -Female -Unknown
4.	Race	-White -Black -Other -Unknown
5.	State Code of Residence	SSA Geographic code
6.	County Code of Residence	SSA Geographic code
7.	Cross-reference Claim Number	
8.	Original Reason for Entitlement	-OASI -DIB -Renal -Both DIB and Renal
9.	Current Reason for Entitlement	-OASI -DIB -Renal -Both DIB and Renal
10.	Dual Entitlement to SSA and RRB benefits	-No -Yes
11.	Previous BIC	Indicates any previous type benefits paid to beneficiary.
12.	Date of Death	Julian date of beneficiary's death.
13.	Current Part A Data a.Entitlement	Julian date.
	b.Termination	Julian date.

Information	Description
14. Current Part B Data	
a. Entitlement	Julian date.
b. Termination	Julian date.
15. Coverage Code	-No coverage or deceased -Part A entitlement only -Part B entitlement only -Part A and B entitlement
16. Termination Code A	Reason for termination to Part A entitlement: -Not terminated -Dead -Nonpayment of premium -Voluntary withdrawal -Entitlement under another claim number -Other termination
17. Termination Code B	Reason for termination to Part B entitlement: -Not terminated -Dead -Nonpayment of premium -Voluntary withdrawal -Entitlement under another claim number -Other termination
18. Prior Part A Data	
a. Entitlement	Julian date of latest prior entitlement.
b. Termination	Julian date of latest prior termination.
19. Prior Part B Data	
a. Entitlement	Julian date of latest prior entitlement.
b. Termination	Julian date of latest prior termination.
20. Bill Code	Coded to indicate party paying SMI. -Individual -Public Assistance

Information	Description
20. Bill Code (con.)	-Private Third Party -Civil Service
21. ZIP Code of Residence	Actual
22. Day 01 Indicator	Coded to indicate if beneficiary born on the first day of the month. -Yes -No
23. End Stage Renal Disease Indicator	Coded to indicate method of original notice of ESRD. -MBR Notice of ESRD -HI Notice of ESRD -NIH Notice of ESRD -MBR and HI Notice of ESRD -MBR and NIH Notice of ESRD -HI and NIH Notice of ESRD -MBR, HI, and NIH Notice of ESRD
24. Century of Birth Indicator	-Prior Century -Current Century
25. Other Entitlement Programs Indicator	-Coded to indicate primary payer if other than Medicare, i.e. Medicaid, Veterans Administration, Black Lung, and/or Workmen's Compensation entitlement.
26. Federal Employee Indicator	-Coded to indicate entitlement as a Federal Employee.

III. Provider of Services Master File

Introduction

Institutional providers of service (hospitals, Long Term Care (LTC), etc.) participate in the Medicare and Medicaid programs through a formal certification procedure which examines the institution's qualifications for furnishing safe and effective care for the beneficiaries of the two programs. The certification procedure is conducted, under federal guidelines, by an agency of the state where the institution is located. Final approval comes from the Health Care Financing Administration. After the initial certification, the qualifications of an institution are reviewed periodically, culminating in a decision to retain or terminate participation.

Source Documents and Input

The observations and decisions of the State agency surveyors, when applying the various criteria which measure an institution's capability of providing acceptable care as well as characteristics such as staffing, bed size, and services, are recorded in a forms package. This package is divided into two sets. The first, called the Survey Report Form (SRF), contains the criteria and the decisions of a surveyor in applying the criteria to the particular institution. The second, comprises the source documents for the Provider of Services (POS) Master File and includes the certification and transmittal (Exhibit A) and the application (Exhibit B). A separate version of the application form is used for each type of provider (hospital, LTC, HHA, etc.).

The complete forms package (POS and SRF) is converted, on a flow basis, on line to the central office update systems over wire transmission lines from the HCFA regional office (RO) where the files of the original source documents are maintained.

Update Mechanism and Quality Control Measures

The update cycle for the POS/SRF system is daily. The data entry and point-of-entry consistency checking, however, are on-line. The data elements are keyed by the regional office using terminals linked by wire to the HCFA Data Center. Data elements not passing consistency checks are earmarked for subsequent corrections by the RO. Nightly, the data elements are sorted and assembled for each provider into a transaction record. Transactions without point-of-entry errors are matched/merged to the MMACS master file. In the matching process the transaction records undergo a second tier of consistency checks (comparison edits, e.g., inordinate increases decreases in bed size or staffing). Only error-free transactions are updated to the master file; those with errors are held on a pending transaction file awaiting resolution by the RO.

Transactions that successfully entered the master file and rejected transactions are disposed of as follows: accretions without error are added to the data base; recertifications replace the associated earlier certifications, which are placed on a separate history file; corrections and termination actions overlay or add the prescribed data elements to the existing record. All new transactions, including those that failed to pass the consistency check, those that failed to match the master data base, and those that were successfully applied to the master data base, are transmitted over the telecommunication network to the regional office. The entire process is set to a daily schedule so that the regions receive the disposition of the records they originally transmitted the morning following their transmission to central office.

In addition to the computer consistency checks, OSDM periodically performs a manual check of selected fields of transactions applied to the POS portion of the master data base. Periodic notes are sent to HSQB showing erroneous transactions which are not amenable to automated edits but are uncovered through comparison to other data sources.

Exhibits C and D detail the record contents of the POS portion for hospitals and LTC's respectively. Record contents for the HHA portion are shown in Exhibit E. During this phase of the update system, a segment indicating errors discovered is appended to the transaction record.

Dependent Systems and Outputs

The POS file is used to support a number of Health Insurance administrative data processing systems. These include the following:

1. RADARS

   RADARS is a rapid data retrieval system that is available to the regional offices and interested central office components that permit lay users to extract current unit record listings and aggregated data through control statements entered via a terminal. Both SRF and POS data are available for extraction.

2. The Update of the Provider Master File

   The POS file furnishes provider records to the system which posts bill information to the records to produce the Provider Statistical and Reimbursement Report and the Provider Monitor Listing. The former is used as an audit tool at time of cost settlement and the latter for program review.

   The system is maintained for all providers in central office and for providers under each intermediary's jurisdiction at the intermediary's installation.

3. Provider Cost Report Monitoring System

   The POS file serves as a control file for this system for SNF and HHA cost reports which monitors the progress of cost reports through the various stages of audit and settlement.

4. Provider Specific File

   The Provider Specific File is developed by the intermediaries for use in the hospital prospective payment system pricing mechanism. A reimbursement price is computed for an individual inpatient hospital stay depending on the Diagnostic Related Group (DRG) the stay is classified in. The Provider Specific File is used in central office to support DRG recalibration; its completeness is measured by comparison to the POS file.

5. Federal Monitoring Surveys

   This effort by HCFA monitors the State agency performance in surveying health care facilities for Medicare/Medicaid certification. The POS/SRF information is

used to support this activity, and the documentation of the monitoring is captured in the MMACS.

6. Chain Ownership Tracking

This system records the identity of corporations/partnerships that own and operate chains of certified providers. Revised SRF forms will capture relevant data, and this will become a subsystem of the MMACS.

7. Case Control System

This system uses POS/SRF data to monitor Regional Office and State agency response to error correction and to control backlogs of surveys.

Recurring tabulations and analyses based on information from the POS file are published on an annual basis. Various listings and tabulations have been produced to satisfy requests from private organizations, other components of HCFA and DHHS, and the Congress. A version of the POS tape file is also prepared in a format suitable for use as input to the table generating software package, which is another means of servicing one-time special requests.

DEPARTMENT OF HEALTH AND HUMAN SERVICES — HEALTH CARE FINANCING ADMINISTRATION

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY STATE SURVEY AGENCY

1. MEDICARE/MEDICAID PROVIDER NO (L1)

3. NAME AND ADDRESS OF FACILITY (L3)

4. TYPE OF ACTION
1 INITIAL SURVEY
2 RECERTIFICATION
3 TERMINATION
4 CHOW
5 VALIDATION
6 COMPLAINT
7 ON SITE VISIT
8 TERMINATION OF ICF BEDS
9 OTHER (L8)

2. STATE VENDOR OR MEDICAID NO (L2)

(L4)

STATE (L5) (L6)

5. EFFECTIVE DATE FOR CHANGE OF OWNERSHIP (L9) M M D D Y Y

6. DATE OF SURVEY (L34) M M D D Y Y

7. PROVIDER/SUPPLIER CATEGORY
TYPE (L7)
01 HOSPITAL — 04 SNF — 09 ESRD — 14 CORF
02 SNF/ICF (DUALLY CERTIFIED) — 05 NHA — 10 ICF — 15 ASC
03 SNF/ICF (DISTINCT PART) — 06 LAB — 11 IMR — 16 HOSPICE
07 X-RAY — 12 RHC
08 OPT SP — 13 PTIP

9 FISCAL YEAR ENDING DATE (L35) M M D D

8. ACCREDITATION STATUS (L10)
0 - UNACCREDITED — 1 - JCAH — 2 - AOA — 3 - OTHER

10. THE FACILITY IS CERTIFIED AS

A. IN COMPLIANCE WITH PROGRAM REQUIREMENTS
COMPLIANCE BASED ON
1 ☐ ACCEPTABLE POC

B. NOT IN COMPLIANCE WITH PROGRAM REQUIREMENTS AND/OR APPLIED WAIVERS

AND/OR APPROVED WAIVERS OF THE FOLLOWING REQUIREMENTS
2 ☐ TECHNICAL PERSONNEL
3 ☐ 24 HR RN
4 ☐ 7-DAY RN (RURAL SNF)
5 ☐ LIFE SAFETY CODE
6 ☐ SCOPE OF SERVICE LIMITED - MEDICAL DIRECTOR - PATIENT ROOM
9 ☐ BEDS PER ROOM

11. LTC PERIOD OF CERTIFICATION
From (a)
To (b) M M D D Y Y

12. TOTAL FACILITY BEDS (L18) M M D D Y Y

13. TOTAL CERTIFIED BEDS (L17) M M D D Y Y

A/B (IF APPLICABLE CODES 1-9) (L12) M M D D Y Y

14. LTC CERTIFIED BED BREAK DOWN — A (L37) 18 SNF; B (L38) 18/19 SNF; C (L39) 19 SNF; D (L42) ICF; E (L43) IMR; F SNF/ICF (LAD) DUALLY CERT

15. FACILITY MEETS 1861 (a) (1) or 1861 (j) (1) (L15) 1-YES 2-NO

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE IN REMARKS)

17. SURVEYOR SIGNATURE (L19) M M D D Y Y

18. STATE SURVEY AGENCY APPROVAL (L20) M M D D Y Y

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
1-FACILITY IS ELIGIBLE TO PARTICIPATE
2-FACILITY IS NOT ELIGIBLE TO PARTICIPATE (L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT ☐

21. 1 STATEMENT OF FINANCIAL SOLVENCY (HCFA-2572)
2 OWNERSHIP AND CONTROL INTEREST DISCLOSURE STATEMENT (HCFA-1513)
3 BOTH OF THE ABOVE ☐

22. ORIGINAL DATE OF PARTICIPATION (L24) M M D D Y Y

23. LTC AGREEMENT BEGINNING DATE (L41) M M D D Y Y

24. LTC AGREEMENT ENDING DATE (L25) M M D D Y Y

26. TERMINATION ACTION (L30)
VOLUNTARY
1- MERGER CLOSURE
2- DISSATISFACTION WITH REIMBURSEMENT
3- RISK OF INVOLUNTARY TERMINATION
4- OTHER REASON FOR WITHDRAWAL
INVOLUNTARY
5- FAILURE TO MEET HEALTH/SAFETY
6- FAILURE TO MEET AGREEMENT
OTHER
7- PROVIDER STATUS CHANGE

27. ALTERNATIVE SANCTIONS

25. LTC EXTENSION DATE (L27) M M D D Y Y

A. SUSPENSION OF ADMISSIONS (L44) M M D D Y Y

B. RESCIND SUSPENSION DATE (L45) M M D D Y Y

28. TERMINATION DATE (L28) M M D D Y Y

29. INTERMEDIARY/CARRIER NO (L31)

30. REMARKS

31. RO RECEIPT OF HCFA-1539 (L32) M M D D Y Y

32. DETERMINATION APPROVAL DATE (L33) M M D D Y Y

DETERMINATION APPROVAL

FORM HCFA-1539 (7-84) (DESTROY PRIOR EDITIONS) — 1. HCFA REGIONAL OFFICE

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0380

HOSPITAL REQUEST FOR CERTIFICATION IN THE MEDICARE/MEDICAID PROGRAM

(READ INSTRUCTION AND INFORMATION COLLECTION STATEMENT ON COVER SHEET PRIOR TO COMPLETION)

HOSPITALS ACCREDITED BY THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS (JCAH) OR THE AMERICAN OSTEOPATHIC ASSOCIATION (AOA) MAY ESTABLISH THEIR ELIGIBILITY TO PROVIDE SERVICES FOR REIMBURSEMENT UNDER THE PROGRAM BY SUBMITTING TO THE DESIGNATED STATE AGENCY INFORMATION ON THIS FORM. THE SIGNING OF THIS FORM ALSO AUTHORIZES THE JCAH OR THE AOA OR ANY OTHER NATIONAL ACCREDITING BODY RECOGNIZED BY THE SECRETARY AS MEETING THE CONDITIONS TO DISCLOSE TO ANY AUTHORIZED REPRESENTATIVE, EMPLOYEE OR AGENT OF THE HEALTH CARE FINANCING ADMINISTRATION A COPY OF THE HOSPITAL'S MOST RECENT ACCREDITATION SURVEY FOR OFFICIAL USE SOLELY IN CONNECTION WITH THE MEDICARE SAMPLE VALIDATION OR SUBSTANTIAL ALLEGATION SURVEY PROGRAM.

IT IS UNDERSTOOD THAT SURVEY INFORMATION DISCLOSED TO THE HEALTH CARE FINANCING ADMINISTRATION SHALL BE TREATED IN ACCORDANCE WITH THE RULE OF CONFIDENTIALITY AND DISCLOSURE CONTAINED IN §401.126(b) AND (c), PART 401 OF SUBCHAPTER A OF TITLE 42 OF THE CODE OF FEDERAL REGULATIONS. THE REGULATION ALLOWS NO DISCRETION ON THE PART OF THE HEALTH CARE FINANCING ADMINISTRATION TO DISCLOSE INFORMATION OBTAINED FROM THE JCAH OR AOA MATERIALS WHICH WERE CONFIDENTIAL AND EXEMPTED FROM PUBLIC DISCLOSURE UNDER THIS PROCEDURE INCLUDE THE ACCREDITATION LETTER AND ACCOMPANYING RECOMMENDATION AND COMMENTS PREPARED BY THE JCAH OR AOA FOR THE BELOW—NAMED HOSPITAL'S ACCREDITATION SURVEY

I. MEDICARE/MEDICAID PROVIDER NUMBER ☐☐☐☐☐☐

VENDOR NUMBER ☐

0 NOT ACCREDITED
1 JCAH ACCREDITED
2 AOA ACCREDITED
3 OTHER
4 BOTH JCAH AND AOA ACCREDITED

EFFECTIVE DATE OF ACCREDITATION ☐☐☐☐☐☐ MMDDYY (M1)

STATE/COUNTY CODE (M3)

EXPIRATION DATE OF ACCREDITATION ☐☐☐☐☐☐ MMDDYY (M2)

STATE REGION CODE (M4)

II. IDENTIFYING INFORMATION

NAME AND ADDRESS OF HOSPITAL (INCLUDE CITY/COUNTY, STATE, ZIP CODE)

FISCAL YEAR ENDING DATE ☐☐☐☐ MMDD

REQUEST TO ESTABLISH ELIGIBILITY IN
1 MEDICARE 2 MEDICAID 3 BOTH (M5) ☐

CLIA I.D. NUMBER(S) (LIST THE CLIA NUMBERS FOR THE HOSPITAL LABORATORIES) (M6)

TELEPHONE NUMBER (INCLUDE AREA CODE) (M7)

RELATED PROVIDER NUMBER ☐☐☐☐☐☐ (M8)

III. TYPE OF HOSPITAL (ENTER ONE FROM COL. A THAT MOST ACCURATELY DESCRIBES THE HOSPITAL. CHECK ALL THAT APPLY IN COL. B.

A
01 SHORT-TERM
02 LONG-TERM
03 CHRISTIAN SCIENCE SANITORIUM
04 PSYCHIATRIC
05 REHABILITATION
06 CHILDRENS
07 ALCOHOL AND/OR DRUG HOSPITAL
(M9) ☐☐

B
1 ☐ REGIONAL REFERAL CENTER
2 ☐ MAYO CLINIC EXCEPTION
3 ☐ SOLE COMMUNITY
4 ☐ CANCER
5 ☐ PSYCHIATRIC UNIT
6 ☐ ALCOHOL/DRUG UNIT
7 ☐ REHABILITATION UNIT
8 ☐ HOSPITAL SWING BED (M10)

IV. PHYSICIAN TRAINING PROGRAMS

A. AFFILIATED WITH A MEDICAL SCHOOL
1 MAJOR
2 LIMITED
3 GRADUATE
4 NO AFFILIATION (M11) ☐

B. RESIDENT PROGRAMS APPROVED BY: (CHECK ALL THAT APPLY)
1 ☐ AMA
2 ☐ ADA
3 ☐ AOA
4 ☐ OTHER
5 ☐ NO PROGRAM

V

TYPE OF CONTROL (ENTER ONE)

VOLUNTARY NON-PROFIT
01 CHURCH
02 PRIVATE
03 OTHER (SPECIFY)

04 PROPRIETARY

(M13) ☐☐

GOVERNMENT
05 FEDERAL
06 STATE
07 LOCAL
08 HOSPITAL DISTRICT OR AUTHORITY

VI

SERVICES PROVIDED: IF BY STAFF, ENTER A "1" IN THE BLOCK(s); IF UNDER ARRANGEMENT, ENTER A "2" IN THE BLOCK(s); IF PROVIDED BY BOTH, ENTER A "3" IN THE BLOCK. LEAVE BLANK IF THE SERVICE IS NOT PROVIDED.

(M14)

1 ☐ ACUTE RENAL DIALYSIS
2 ☐ ALCOHOL AND/OR DRUG SERVICES
3 ☐ ANESTHESIA SERVICES
4 ☐ BLOOD BANK
5 ☐ BURN CARE UNIT
6 ☐ CHIROPRACTIC SERVICES
7 ☐ CORONARY CARE UNIT
8 ☐ DENTAL SERVICES
9 ☐ DIETETIC SERVICES
10 ☐ EMERGENCY SERVICES (ORGANIZED)
11 ☐ HOME CARE PROGRAM
12 ☐ HOSPICE
13 ☐ INPATIENT SURGICAL SERVICES
14 ☐ INTENSIVE CARE UNIT
15 ☐ LABORATORY SERVICE (CLINICAL)
16 ☐ LABORATORY SERVICE (ANATOMICAL)
17 ☐ LONG TERM CARE UNIT
18 ☐ NEONATAL NURSERY
19 ☐ NUCLEAR MEDICINE SERVICES
20 ☐ OBSTETRICS
21 ☐ OCCUPATIONAL THERAPY SERVICES
22 ☐ OPEN HEART SURGERY FACILITIES
23 ☐ OPERATING ROOM(s)
24 ☐ OPTOMETRIC SERVICES
25 ☐ ORGAN BANK
26 ☐ ORGAN TRANSPLANT SERVICES
27 ☐ OUTPATIENT SERVICES
28 ☐ OUTPATIENT SURGERY UNIT
29 ☐ PEDIATRIC SERVICES
30 ☐ PHARMACY
31 ☐ PHYSICAL THERAPY SERVICES
32 ☐ POSTOPERATIVE RECOVERY ROOMS
33 ☐ PSYCHIATRIC SERVICES
34 ☐ RADIOLOGY SERVICES (DIAGNOSTIC)
35 ☐ RADIOLOGY SERVICES (THERAPEUTIC)
36 ☐ REHABILITATION SERVICES
37 ☐ RESPIRATORY CARE SERVICES
38 ☐ SELF CARE UNIT
39 ☐ SHOCK TRAUMA
40 ☐ SOCIAL SERVICES
41 ☐ SPEECH PATHOLOGY SERVICES

VII.

NUMBER OF EMPLOYEES SALARIED BY HOSPITAL (FULL-TIME EQUIVALENT)

PHYSICIANS (SALARIED ONLY) ☐☐☐☐.☐☐ (M15)	LICENSED REGISTERED NURSES ☐☐☐☐.☐☐ (M16)	REGISTERED PHARMACISTS ☐☐☐☐.☐☐ (M17)	OCCUPATIONAL THERAPISTS ☐☐☐☐.☐☐ (M18)	PHYSICAL THERAPISTS ☐☐☐☐.☐☐ (M19)
RESIDENTS (PHYSICIANS) ☐☐☐☐.☐☐ (M20)	LICENSED PRACTICAL/LICENSED VOCATIONAL NURSES ☐☐☐☐.☐☐ (M21)	MEDICAL SOCIAL WORKERS ☐☐☐☐.☐☐ (M22)	SPEECH THERAPISTS ☐☐☐☐.☐☐ (M23)	PHYSICIAN ASSISTANTS ☐☐☐☐.☐☐ (M24)
INHALATION THERAPISTS ☐☐☐☐.☐☐ (M25)	DIETITIANS ☐☐☐☐.☐☐ (M26)	CERTIFIED REGISTERED NURSE ANESTHETIST (CRNA) ☐☐☐☐.☐☐ (M27)		ALL OTHERS ☐☐☐☐.☐☐ (M28)

WHOEVER KNOWINGLY OR WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION ON THIS FORM MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE, OR WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OR CONTRACT WITH THE STATE AGENCY OR THE SECRETARY AS APPROPRIATE.

NAME OF AUTHORIZED REPRESENTATIVE (SIGNATURE)	TITLE (TYPED)	DATE ☐☐☐☐☐☐ M M D D Y Y (M29)

FORM HCFA-1514 (4-86)

Provider of Services Hospital Record

	Information	Description
1.	Provider Number	Six position number identifies a specific facility. First two positions are the State code. Positions 3 and 4 are coded as follows: 00-08--Short stay hospital 09--Multihospital complex 12--Alcohol/Drug hospital 18--Neighborhood health center 19--Christian Science 20-22--Long stay 30--Rehabilitation hospital 33--Children's hospital 40-44--Psychiatric D0-D9--Denied participation M0-M9--Not participating but meets Medicare definition of a hospital. P0-P9--Not participating and does not meet Medicare definition of a hospital. S0-S9--Psychiatric unit T0-T9--Rehabilitation unit U0-U9--Swing-bed hospital (SNF) V0-V9--Alcohol/drug unit Positions 5 and 6 are numeric except for emergency and Federal hospitals which are coded E and F, respectively, in the 6th position.
2.	Intermediary Number	Number identifying the hospital's intermediary.
3.	Effective Date of Participation	Date hospital entered Medicare program.
4.	Date of Application	Date hospital initially applied for participation.
5.	Surveyor Date	Date State surveyor completed examination of hospital.
6.	State Survey Agency Approval Date	Date State approved survey of hospital.

Exhibit C

	Information	Description
7.	Termination Date	Date hospital was terminated from program.
8.	Determination Approval Date	Date Regional Office approved State findings.
9.	Regional Office Receipt Date	Date Regional Office received survey.
10.	Category of Provider	-General hospital -Psychiatric hospital -Christian Science
11.	Type of Action	-Initial certification -Recertification -Reconsideration -Change of Ownership
12.	Eligibility Determination	-Eligible -Ineligible to participate
13.	Title VI Compliance	-In compliance -No information
14.	Statement of Financial Solvency	-Settlement filed -No information
15.	Reason for Termination Code	-Voluntary closure, merger -Voluntary withdrawal -Involuntary withdrawal -Failure to abide by agreement -Emergency hospital changed to full participation
16.	Supplemental Information on Hospitals not in Full Compliance	-Emergency hospitals -Nonemergency hospital -Meets Medicare definition -Does not meet Medicare definition
17.	Status of Compliance with Program Requirements	-Coded indication showing basis for compliance to regulations. -Information available upon request.
18.	Certified Beds	Number of certified beds
19.	Total Beds	Total number of beds
20.	Name of Hospital	
21.	Street Address	

	Information	Description
22.	City and State	
23.	ZIP Code	
24.	Type of Hospital	-General short-term -General long-term -Psychiatric short-term -Psychiatric long-term -Specialty short-term -Specialty long-term -Christian Science
25.	Type of Control	-Church -Other voluntary nonprofit -Proprietary -State -County -City -City/County -Hospital district -Federal
26.	State Code of Hospital	SSA geographic code indicating State of hospital's residence.
27.	County Code of Hospital	SSA geographic code indicating county of hospital's residence.
28.	State Region Code of Hospital	Code assigned by States who divide themselves into regions.
29.	PRO Code	Code identifying PRO area within State.
30.	Authorized Date	Date application was completed.
31.	Fiscal Year Ending Date	Date fiscal year ends.
32.	Previous Intermediary Number #1	Number of intermediary immediately prior to present one.
33.	Previous Intermediary Number #2	Number of intermediary prior to previous intermediary #1.
34.	FIPS MSA Code	Metropolitan Statisitical Area Code
35.	Intermediary Type	-HCFA -Blue Cross -Group Health -Commercial

Exhibit C

	Information	Description
35.	Intermediary Type (con.)	-State agency -Other
36.	Provider Number of Parent Organization	
37.	Previous Provider Number	If the institution changed status, e.g., long-term to short-term, the previous provider number is placed here.
38.	Status Code	-Accretion (initial) record -Change or correction including resurvey -Delete -Terminated
39.	Last Transaction Code	-Initial -Resurvey -Correction
40.	Participation Code	Indicates type of program participation: -Medicare -Medicaid -Medicare and Medicaid -Nonparticipation
41.	Facility Group	Hospital
42.	Region Code	HCFA region
43.	HCFA MSA	Metropolitan Statistical Area code
44.	MSA Size Code	Code categorizing size by Census population.
45.	Run Date of Accretion	Date initial record entered system.
46.	Run Date of Last Transaction	Date last transaction entered system.
47.	Change of Ownership Count	Number of times the facility has changed ownership.
48.	Resurvey Count	Number of resurveys conducted under present ownership.
49.	Prior Owner's Dates	-Change of ownership -Certification -Termination

	Information	Description
50.	Survey Date	Date of survey
51.	Resident Programs Approved	Four position field. First position American Medical Association (AMA), second position American Dental Association (ADA), third position American Osteopathic Association (AOA), fourth position "Other". Each position coded "1" for approval, "0" for not approved or no program.
52.	Facilities and Services	Thirty-three position field. Each position coded as follows:

1- Blood bank
2- Clinical laboratory
3- Pathology laboratory
4- Electrocardiograph
5- Electroencephalograph
6- Pharmacy
7- Occupational therapy department
8- Physical therapy department
9- Intensive care unit
10- Organized outpatient department
11- Emergency care
12- Home care unit
13- Operating room
14- Post operative recovery room
15- Medical social service department
16- X-Ray, diagnostic
17- Nuclear medicine
18- Cobalt and radiation therapy
19- Psychiatric and inpatient care unit
20- Rehabilitation unit
21- Extended care unit
22- Renal dialysis
23- Open heart surgery
24- Coronary care unit
25- Oral surgery
26- Obstetrics-Gynecology department
27- Pediatric department
28- Speech therapy department

-Provided by staff
-Provided under arrangement
-Not provided

Exhibit C

	Information	Description
52.	Facilities and Services (con.) 29- Pulmonary function department 30- Organ bank 31- Ambulatory preoperative unit 32- Nursery 33- Shock Trauma	
53.	Salaried Physicians	Number of physicians salaried by hospitals.
54.	Number of Employees by Type Registered nurse Licensed practical nurse Pharmacist Social worker Occupational therapist Speech therapist Physical therapist Other employees Total staff	
55.	Affiliation with a Medical School	-Major -Limited -Graduate -No affiliation
56.	Accreditation Verified	-JCAH accredited -AOA accredited -Not accredited or no information
57.	Change in Accreditation	-Gained accreditation -Lost JCAH accreditation -Lost AOA accreditation -No change
58.	Date Approved for Emergency Services	Approval date for hospitals with "E" in sixth position of provider number.
59.	JCAH Survey Date	Date surveyed by the Joint Commission on Accreditation of Hospitals.
60.	Indicator of State and Survey of JCAH/AOA Hospitals	-Sample validation -Monitoring hospital -Complaint investigation -Monitoring because of complaint results

Information	Description
61. Emergency Election Code (Emergency Hospitals only)	-Emergency hospital does not elect participation -Emergency hospital elects participation

Exhibit D

Provider of Services Long Term Care Record

	Information	Description
1.	Provider Number	Six position number identifies a specific facility. First two positions are State code. Positions 3 and 4 are coded as follows: -Medicare participating SNF's -Christian Science -Medicaid only participating SNF's -Medicaid participating ICF's -Medicaid participating IMR's -Nonparticipating, does not meet definition of a SNF. -Nonparticipating, meets definition of a SNF. Positions 5 and 6 are always numeric.
2.	Intermediary Number	Number identifying the Medicare intermediary for a participating LTC.
3.	Effective Date of Participation	Date LTC entered Medicare Program.
4.	Date of Application	Date LTC initially applied for participation.
5.	Surveyor Date	Date State surveyor completed examination of LTC.
6.	State Survey Agency Approval Date	Date State agency approved survey of LTC.
7.	Termination or Nonrenewing Date	Date LTC was terminated from Medicare program or contract was not renewed.
8.	Determination Approval Date	Date Regional Office approved State findings.
9.	Regional Office Receipt Date	Date Regional Office received survey.

Information	Description
10. Category of Provider	-SNF -Christian Science -ICF (Intermediate Care Facility) -IMR (Institution for the Mentally Retarded)
11. Type of Action	-Initial certification -Recertification -Reconsideration -Change of ownership -Validation -Investigation
12. Eligibility Determination	-Eligible -Ineligible to participate
13. Title VI Compliance	-In compliance -No information
14. Statement of Financial Solvency	-Statement filed -No Information
15. Reason for Termination Code	-Voluntary closure, merger -Voluntary withdrawal -Involuntary, no longer meets requirements -Failure to abide by agreement -LTC status change
16. Supplemental Information on Facilities not in Full Compliance	-Meets definition of a LTC -Does not meet definition -Part of facility meets definition of an LTC
17. Status of Compliance with Program Requirements	Coded indicators showing basis for compliance to regulations defining LTC's. Details available upon request.
18. Certified Beds	Coded to indicate LTC category -Medicaid SNF -Medicare/Medicaid SNF -Medicare SNF -ICF -IMR -LTC category will be followed by number of beds certified for that facility.

Exhibit D

	Information	Description
19.	Total Beds	
20.	Name of Facility	
21.	Street Address	
22.	City and State	
23.	ZIP Code	
24.	Type of LTC Facility	-SNF -ICF -SNF/ICF -IMR
25.	Type of Control	-Church -Other nonprofit -Proprietary -State -County -City -City/County -Hospital district
26.	State Code of LTC	
27.	County Code of LTC	
28.	State Region Code of LTC	Code assigned by States who divide themselves into regions.
29.	PRO Code	
30.	Authorized Date	Date application was completed.
31.	Fiscal Year Ending Date	Date fiscal year ends.
32.	Previous Intermediary Number #1	Number of intermediary immediately prior to present one.
33.	Previous Intermediary Number #2	Number of intermediary prior to previous intermediary #1.
34.	Intermediary Type	-HCFA -Blue Cross -Group Health -Commercial -State Agency -Other

	Information	Description
35.	Hospital Based Indicator	Coded to indicate if facility is hospital based.
36.	Provider Number of Parent Organization	
37.	Previous Provider Number	If the institution changed status, e.g., IMR to SNF, the previous provider number is placed here.
38.	Status Code	-Accretion (initial) record change or correction including resurvey -Delete -Terminated
39.	Last Transaction Code	-Initial -Resurvey -Correction
40.	Participation Code	-Medicare -Medicaid -Medicare and Medicaid -Nonparticipation
41.	Facility Group	Long-term care
42.	Region	HCFA region
43.	HCFA MSA	Metropolitan Statistical Area code
44.	MSA Size Code	Code categorizing size by Census population.
45.	Run Date of Accretion	Date initial record entered system.
46.	Run Date of Last Transaction	Date last transaction entered system.
47.	Change of Ownership Count	Number of times the facility has changed ownership.
48.	Resurvey Count	Number of surveys conducted under present ownership.
49.	Survey Date	Date on site certification survey was conducted.
50.	Prior Owner's Date	-Change of ownership -Certification

Exhibit D

Information	Description
50. Prior Owner's Date (con.)	-Termination
51. Program Eligibility	-Medicare -Medicaid -Both
52. Services	Nineteen position field. Each position coded as follows:
1- Nursing 2- Physical therapy 3- Outpatient physical therapy 4- Occupational therapy 5- Speech pathology 6- Outpatient speech pathology 7- Social services 8- Recreational activities 9- Pharmacy 10-Clinical laboratory 11-Diagnostic X-Ray 12-Administration and storage of blood 13-Dentistry 14-Podiatry 15-Ophthalmology 16-Psychological services 17-Dietary services 18-Housekeeping services 19-Other	-Provided by staff -Provided under arrangement -Not provided
53. Completion Date for ICF Life Safety Code Compliance	
54. SNF/ICF Period of Certification	
From Date	
To Date	
55. SNF/ICF Cancellation Date	Date (YY-MM-DD) contract with SNF/ICF is cancelled.
56. Agreement Ending Date	Date RO designates as date Medicare contract ends.

	Information	Description
57.	Cancellation Date	Date (YY-MM-DD) RO designates for cancellation of Medicare contract.
58.	SNF/ICF Agreement Date	Date beyond normal ending date granted to correct deficiencies.
59.	Distinct Part Indicator	-Facility contains a certified distinct part. -Facility does not contain a certified distinct part.
60.	Number of Beds--Total Facility	
61.	Number of Employees--Entire Facility	
	Registered professional nurses Licensed practical nurses Nurses aides/orderlies All others	
62.	Medicaid Termination Date	Date LTC was terminated from Medicaid participation.
63.	Number of Title XVIII Certified Beds	
64.	Number of Title XVIII and XIX Certified Beds	Title XVIII is Medicare, Title XIX is Medicaid.
65.	Number of Title XIX Certified Beds	
66.	Number of SNF/ICF Swing Beds	Same beds certified for either SNF or ICF utilization depending on status of occupant.
67.	Agreement Beginning Date	Date agreement to participate was executed with HCFA.

Exhibit E

Provider of Services Home Health Agency Record

	Information	Description
1.	Provider Number	Six position number identifies a specific facility. First two positions are the State code. Positions 3 and 4 are coded as follows: -individual HHA -HHA subunit of non-profit or proprietary -subunit of a State-wide HHA Positions 5 and 6 are numeric
2.	Intermediary Number	Number identifying the HHA's intermediary.
3.	Effective Date of Participation	Date HHA entered Medicare program.
4.	Date of Application	Date when HHA initially applied for participation.
5.	Surveyor Date	Date State surveyor completed examination of HHA.
6.	State Agency Survey Approval Date	Date State agency approved survey of HHA.
7.	Termination Date	Date HHA was terminated from the program.
8.	Determination Approval Date	Date Regional Office approved State findings.
9.	Regional Office Receipt Date	Date Regional Office received survey.
10.	Type of Action	-Initial certification -Recertification -Reconsideration -Change of ownership -Validation -Investigation
11.	Eligibility Determination	-Eligible -Ineligible to participate
12.	Title VI Compliance	-In Compliance -No Information

	Information	Description
13.	Statement of Financial Solvency	-Statement filed -No information
14.	Reason for Termination Code	-Voluntary closure, merger -Voluntary withdrawal -Involuntary -Failure to abide by agreement
15.	Name of Facility	
16.	Street Address	
17.	City and State	
18.	ZIP Code	
19.	Type of HHA	-Visiting Nurse Association -Combination government and voluntary agency -Office health agency -Rehabilitation facility based program -Hospital based program -SNF based program -Proprietary -Private nonprofit -Other
20.	Type of Control	-Voluntary nonprofit other than church -Church -State government -Local government -Combination government and voluntary -Proprietary -Private nonprofit
21.	State Code of HHA	SSA geographic code indicating State of HHA's residence.
22.	County Code of HHA	SSA geographic code indicating county of HHA's residence.
23.	State Region Code	Code assigned by States who divide themselves into regions.
24.	PRO Code	
25.	Authorized Date	Date application was completed.
26.	Fiscal Year Ending Date	Date fiscal year ends.

Exhibit E

	Information	Description
27.	Previous Intermediary Number #1	Number of intermediary immediately prior to present one.
28.	Previous Intermediary Number #2	Number of intermediary prior to previous intermediary #1.
29.	Switch Date of Intermediary	Date of last intermediary change.
30.	Intermediary Type	-HCFA -Blue Cross -Group Health -Commercial -State Agency -Other
31.	Provider Number of Parent Organization	
32.	Previous Provider Number	If the institution changes status, e.g., SNF to HHA, the previous provider number is placed here.
33.	Status Code	-Accretion (initial) record change or correction including resurvey -Delete -Terminated
34.	Last Transaction Code	-Initial -Resurvey -Correction
35.	Participation Code	-Medicare -Medicaid -Medicare and Medicaid -Nonparticipation
36.	Facility Group	Home Health Agency
37.	Region	HCFA Region
38.	MSA	Metropolitan Statistical Area
39.	MSA Size Code	
40.	Run Date of Accretion	Date initial record entered system.
41.	Run Date of Last Transaction	Date last transaction entered system.
42.	Change of Ownership Count	Number of times the facility has changed ownership.

Information	Description
43. Resurvey Count	Number of resurveys conducted under present ownership.
44. Prior Owner's Dates	-CHOW (Change of Ownership) date -Certification date -Termination date
45. Survey Date	Date on site certification survey was conducted.
46. Medicaid-State Vendor Number	
47. Area of Operation	-Less than county wide -Single county -Multicounty -Unknown
48. Number of Employees by Type Registered professional nurse Licensed practical nurse Qualified physical therapist Qualified occupational therapist Qualified speech pathologist or audiologist Home health aides Other	
49. Services 1- Nursing Care 2- Physical therapy 3- Occupational therapy 4- Speech therapy 5- Medical social services 6- Home health aide 7- Interns and residents 8- Nutritional guidance 9- Pharmaceutical service 10-Appliances and equipment service 11-Vocational guidance 12-Other	Twelve position field. Each position coded as follows: -Provided by staff -Provided under arrangement -Not provided

IV. Bill Records from Institutional Providers

Introduction

This chapter describes the statistical files created from bills submitted by institutional providers. These are primarily hospitals, skilled nursing facilities, home health agencies, rural health clinics, and renal dialysis facilities. They provide Medicare services for both Part A and Part B of the program. They submit their bills to HCFA by way of the Part A intermediary selected by them to process their claims.

HCFA has the basic responsibility for controlling and monitoring intermediary/carrier payments to beneficiaries or providers. Intermediaries and carriers are responsible for verifying a beneficiary's eligibility, type of coverage, deductible, etc., before a claim is paid. When a beneficiary is admitted as an inpatient to a hospital or skilled nursing facility, the provider must determine if hospital entitlement exists. The provider notifies their servicing intermediary of the admission at the time it submits a bill. The intermediary then submits the admission data to HCFA. HCFA's query system processes these queries against its Health Insurance Master file to determine the beneficiary's status. If the beneficiary is covered, HCFA will then prepare an admission notice for in-house subsequent processing and will also transmit a query reply that is used by the intermediary to update its own history files.

Preparation of the Query Record

A query (admission) record must be submitted by the intermediary for all Medicare beneficiary inpatient or skilled nursing facility (SNF) admissions. This is needed by HCFA to maintain accurate benefit period (spell-of-illness) information.

The notice of an inpatient hospital admission, when transmitted to HCFA results in recording the beginning of services in the patient's utilization record; i.e., the creation of an "open item". This open item remains on the individual's record until it is closed by a discharge bill. See Exhibit A for contents of the Admission Record.

Queries are also received by HCFA for Supplementary Medical Insurance (SMI) claims. However, after the carrier has verified the beneficiary's entitlement and deductible status, if the deductible is met, subsequent claims are not normally queried. SMI claims involving non-inpatient psychiatric or physical therapy expenses must be queried unless the carrier has information in file from a previous reply indicating that the applicable money limits have been reached. Since current statistics are not being obtained from SMI queries, this manual does not cover those records.

Approximately 11,500,000 admission notice (or query) records are received annually.

One Hundred Percent Files

Provider bills submitted by intermediaries to HCFA enter the statistical system only after they have been updated to the Health Insurance Master record (HIM). When the bill records are updated to the HIM, the enrollees' demographic characteristics such as age, sex, race, and residence are appended. These records, which now contain both billing and demographic information, are cumulated weekly and then entered into the statistical system.

Exhibits B, C, D, and E contain record formats of the bill records which comprise the one hundred percent bill files. The bill records are extracts of the provider submitted HCFA-1450 (UB-82, Uniform Bill) shown as exhibit F. The record formats are as follow:

Exhibit B - Inpatient Hospital and Skilled Nursing Facility Record Format. This record contains information from Part A inpatient hospital and inpatient skilled nursing facility bills.

Exhibit C - Home Health Agency Record Format. This record contains Part A and Part B HHA billing information. If a bill contains both Part A and Part B information, two separate tape records are prepared.

Exhibit D - Outpatient Bill Record Format. This record contains Part B outpatient billing information. It is also used for rural health clinic and outpatient renal dialysis services.

Exhibit E - Hospice Record Format. This record contains information on hospice services rendered.

The one hundred percent provider bill files, along with the one hundred percent file of payment records, are used to prepare control tables and a series of monthly, quarterly, semi-annual, and annual tabulations. Some tables are based on all of the records and others are based on samples which are inflated.

Diagnostic and Surgical Procedure Data

In addition to the one hundred percent utilization bill files described above, there are files containing diagnostic and surgical procedure codes. These are reported directly by the intermediary from provider submitted codes. The information on each type of bill is as follows:

Inpatient Hospital - Principal diagnosis and principal surgical procedures (if any)

Inpatient SNF - Admitting diagnosis

Outpatient Hospital - Nature of illness and surgical procedure (if any)

Home Health Agency - (A or B) - Diagnosis

Prior to October 1983, the diagnostic and surgical information was reported in narrative form (up to 45 characters for diagnosis and 41 characters for surgery) for samples of bills only. Only one diagnosis and surgical procedure (if any) was coded. The coding system in use since 1979 is ICD-9-CM, Volumes I and II, for diagnosis and ICD-9-CM, Volume III, for surgical procedures. For services before 1971, ICDA-7 was used; and from 1971 - 1978, it was ICDA-8.

In October 1983, hospitals were required to report only ICD-9-CM codes for inpatient hospital bills. Narratives were no longer permitted. Inpatient hospital bills were to contain codes for the principal diagnosis and up to four additional diagnoses and principal surgical procedure and up to two additional surgical procedures, if any. Inpatient hospital bills also were required to contain a Diagnosis Related Group (DRG) number to determine reimbursement for prospective payment. The DRG is assigned by the fiscal intermediary by processing the billing information through a computer program called GROUPER.

Medicare bills other than inpatient hospital, outpatient, home health, and skilled nursing facility were still reporting either narratives or codes until April 1985 when only ICD-9-CM codes were permitted.

Annual Volume of Records for the One Hundred Percent Files - 1985

1. Inpatient Bills - 11 Million
2. Home Health Agency Bills - 5 Million
3. Outpatient Bills - 29 Million
4. Skilled Nursing Facility Bills - 0.8 Million

These bill records, along with approximately 200 million Part B Payment Records, are on monthly files based on the month processed in HCFA. Each monthly file contains all types of bills in sequence by processing week and Health Insurance Claim Number and comprises approximately 60 reels of magnetic tape.

Exhibit A

Part A (Query) Admission Notice Contents

	Information	Description
1.	HI Claim Number	Beneficiary's Health Insurance claim number.
2.	Admission Date	Julian date beneficiary admitted as inpatient to hospital or SNF.
3.	Query Code	-Initial request -Delete previous request -Follow-up request -Status request
4.	Beneficiary Name a. Surname b. First Initial c. Middle Initial	First six letters of surname
5.	Date of Birth	Julian date of beneficiary's birth
6.	Sex	-Male -Female -Unknown
7.	Type of Facility	-Christian Science SNF -Psychiatric -TB -General Care -Regular SNF
8.	Receipt Date	Date admission notice was received into the HCFA EDP system.
9.	Process Date	Date admission notice was processed.
10.	Disposition Code	This code identifies the type of reply made by HCFA to the intermediary. Codes basically indicate approval, rejection, qualified approval, or just an acknowledgement of the receipt of the admission notice.
11.	Reason for Entitlement Trailer Code	-No disability or ESRD involvement. -Beneficiary currently insured due to disability. No ESRD involvement.

	Information	Description
11.	Reason for Entitlement Trailer Code (con.)	-Beneficiary currently insured due solely to ESRD. -Beneficiary currently insured for disability with prior or current ESRD involvement. -Beneficiary currently insured due to age (OASDI) with prior or current ESRD involvement. -Beneficiary currently entitled to Part A coverage due to buy-in provisions with prior or current ESRD involvement.
12.	Intermediary Number	Intermediary's identification number.
13.	Provider Number	Identification number of the provider submitting the claim.

Exhibit B

Inpatient Hospital and Skilled Nursing Facility Bill Records

	Information	Description
1.	Health Insurance Claim Number	Number that identifies the beneficiary.
2.	Beneficiary Identification Code	Identifies beneficiary's relationship to SSN. For bill and stay records this field is an equatable BIC.
3.	Cross Reference Claim Number	Beneficiary's cross-reference Health Insurance claim number.
4.	Beneficiary's Name a. Surname b. Initial - 1st c. Initial - 2nd	
5.	State Code of Residence	SSA standard State code.
6.	County Code of Residence	SSA standard county code.
7.	Date of Birth	Format YYDDD. Julian date. Date of beneficiarys birth (from Master Record).
8.	Sex Code	Code which identifies the sex of the beneficiary (from Master Record). -Unknown -Male -Female
9.	Race Code	Code which identifies the race of the beneficiary (from Master Record). -Unknown -White -Black -Other
10.	ZIP Code of Residence	Beneficiary's ZIP code from Master Record.
11.	Medicare Status Code	Indicates reason for Medicare entitlement as of a point in time. -Aged without ESRD -Aged with ESRD -Disabled without ESRD -Disabled with ESRD -ESRD only

Information	Description
12. Current Reason for Entitlement	Indicates the reason for the beneficiary's current entitlement to Medicare benefits. -OASI -DIB -Renal -DIB and Renal
13. Original Reason for Entitlement	Indicates the reason for the beneficiary's original entitlement to Medicare benefits. -OASI -DIB -Renal -DIB and Renal
14. End Stage Renal Disease Indicator	This code indicates the source of the notice of end stage renal disease. -No ESRD -MBR -HI -NIH -MBR and HI -MBR and NIH -HI and NIH -MBR, HI, and NIH -Clerical -MBR and Clerical -HI and Clerical -NIH and Clerical -MBR, HI and Clerical -MBR, NIH, and Clerical -HI, NIH, and Clerical -MBR, HI, NIH and Clerical
15. HMO Indicator	-HMO involvement -No HMO involvement
16. Number of HMO Periods	Counter for the number of HMO periods. -Actual number of periods. -Period number nine or greater.
17. HMO Effective Date	Format YYDDD Julian start date of HMO period.
18. HMO Termination Date	Format YYDDD Julian termination date of HMO period.

Exhibit B

19.	HMO Number	Plan number for Health Maintenance Organization.
20.	HMO Option Code	For lock-in beneficiaries: -HCFA to process all provider bills. -HMO to process only in-plan Part A and in-area Part B bills. -HMO to process all Part A and Part B bills. For non-lock-in beneficiaries: -HCFA to process all provider bills. -HMO to process only in-plan Part A and in-area Part B bills.
21.	Bill Covers Period	Statement covers period, Julian date.
	a. From Date	Beginning date of bill.
	b. Through Date	Ending date of bill.
22.	Query Code	Code indicating status of bill: -Credit adjustment -Interim bill -Final bill -Discharge bill -Discharge notice -Debit adjustment
23.	Transaction Code	Indicates the type of institutional provider. -Christian Science SNF -Psychiatric hospital -Tuberculosis hospital -General Care hospital -Regular SNF -Home Health Agency -Outpatient -Comprehensive Outpatient Rehabilitation Facility -Hospice
24.	Adjustment Code	Code indicating a cancel only bill: -Coverage transfer -Plan transfer -Scramble -Duplicate billing -Other

	Information	Description
25.	Spider Indicator	-Bill submitted through on-line system otherwise blank
26.	Employment Related	-Complementary insurance -Employment related -Both complementary insurance and employment related -Neither complementary insurance nor employment related
27.	Provider Number	Identifier for the provider of services
28.	Special Unit Code	Derived from the provider number 3rd digit, which has been reset to zero. A value other than blank indicates a part of a short stay hospital not covered by PPS. -Provider number not changed -Psychiatric unit -Rehabilitation unit -Swing-bed hospital designation -Alcohol/drug unit
29.	Intermediary Number	Identification number of the intermediary processing the bill.
30.	Date Approved	Julian date bill approved by intermediary.
31.	Date Forwarded	Julian date bill received by intermediary.
32.	Date of Admission	Format YYDDD. Julian date. Date admitted to institution.
33.	Patient Status Code	Possible Values -Discharged -Died -Still patient
34.	Discharge Date	Format YYDDD. Julian Date. Date of discharge from institution.
35.	Date of Death	Format YYDD. Julian Date. Beneficiary's date of death reported on the bill.

Exhibit B

Information	Description
36. Total Covered Days	
37. Cost Report Days	Number of days which would have been Medicare covered days if another primary payer were not involved or if a beneficiary had fewer days available than were needed by a PPS bill.
38. Lifetime Reserve Days Used	Number of lifetime reserve days used this stay.
39. Professional Component Charges	As required by TEFRA.
40. Primary Payor Code	Information about a primary payor (with Medicare as secondary payor.) The following are the valid codes: -Working aged beneficiary/spouse with an employer group health plan -ESRD beneficiary in the 12 month coordination period with an employer group health plan -Conditional payment by Medicare; future reimbursement expected -Automobile no-fault insurance or any liability insurance -Workers' Compensation including black lung -VA, PHS, or other federal agency -Medicare is primary payor
41. Primary Payor Amount	The amount of Medicare covered expenses paid by primary payor. Zero for Medicare.
42. Non-Covered Ancillary Charges	Non-covered charges for all ancillaries.
43. Inpatient Deductible	Deductible to be paid by beneficiary.
44. Coinsurance Days and Amount a. Days b. Rate per day c. Total Amount	

	Information	Description
45.	Total Deductions	Represents total non-covered charges, total deductibles, and coinsurance amounts.
46.	Blood Deductible pints	Number of whole pints of blood.
47.	Blood Deductible Charge/Pint	Zeroes if no charges for blood.
48.	Blood Deductible Charges	
49.	Total Blood Deductions	
50.	Blood Code	Constant A
51.	Blood Pints Furnished	Number of whole pints furnished.
52.	Blood Pints Replaced	
53.	Blood Pints Not Replaced	
54.	Blood Charge/Pint	Zero if no charge for blood.
55.	Total Blood Charges	
56.	Total Blood Non-Covered Charges	
57.	Non-Covered From Date	YYDDD - Beginning date of stay.
58.	Non-Covered Through Date	YYDDD - Ending date of stay.
59.	Open Item From Date	YYDDD - From date of open item used to link the bill to an earlier spell.
60.	Open Item Through Date	YYDDD - Latest date of open item used to link the bill to a more current spell.
61.	Non-Payment Code	Code indicating a cancel only bill. -Covered Workmens' Compensation -Benefits exhausted -Custodial care -Non-covered -Payment refused -Workmens' Compensation

Exhibit B

Information	Description
62. Total Charges	Total charges for all accommodations and services.
63. Reimbursement Amount	Reimbursement amount from bill. Reimbursement amount for interim payments made to the hospital. Final reimbursement is made on a cost basis based on the cost report each hospital is required to prepare at the end of their fiscal year. Beginning October 1983, for most hospitals, this amount is based on the DRG.
64. Diagnosis Data a. Number of Diagnosis Codes	
b. Principal Diagnosis Code	Coding Based on ICD-9-CM, Volumes I and II. Identifies the condition chiefly responsible for the patient's hospitalization.
c. Additional Diagnosis	This field may be repeated for up to four additional diagnoses.

NOTE: For SNF bills Item 64 is used for admitting diagnosis.

65. Surgery Data a. Number of Surgery Codes	
b. Principal Surgery	Coding based on ICD-9-CM, Volume III.
c. Additional Surgery	This field may be repeated for up to two additional surgical procedures.
d. Date of Surgery	Julian date on which surgery was performed.
66. Non-Covered Charges	
67. ESRD Indicator	-Other than transplant -Transplant, unspecified donor -Transplant, living donor -Transplant, cadaveric donor

	Information	Description
68.	Qualifying Dates	Julian date of qualifying stay for SNF.
	a. From Date	Beginning date of stay
	b. To Date	Ending date of stay
69.	DRG Code	Code assigned to indicate diagnosis related group to which this claim belongs for payment purposes.
70.	Discharge Destination	-To home, self care -To short-term hospital -To SNF -To ICF -To other type facility -To home, health service care -Left against medical advice -Died -Still patient
71.	DRG Outlier Code	-No outlier -Day otlier -Cost outlier
72.	Date Guarantee of Payment Began	Format YYDDD. Julian date.
73.	Date UR Notice Received	Format YYDDD. Julian date.
74.	Date Active Care Ended	Format YYDDD. Julian date.
75.	Date Benefits Exhausted	Format YYDDD. Julian date.
76.	Outlier Amount	Additional reimbursement amount approved due to an outlier situation.
77.	HMO Paid/Readmission Indicator	-Not paid by an HMO -Paid by an HMO -Readmission within 7 days of a prior discharge -Both conditions present
78.	KPON Indicator	-Bill must force a new spell-of-illnes even if it is within 60 days of a prior spell-of-illness.

Exhibit B

	Information	Description
78.	KRON Indicator (con.)	-KRON indicator was submitted in a bill which was not linked to a spell-of-illness.
79.	Value Code	Description and codes are at the end of the Glossary.
80.	Value Code Amount	Amount related to the value code.
81.	Revenue Center Code	Code identifying each service incurred during the billing period.
82.	Units	
83.	Service Date	MMDD - May be zeroes.
84.	Rate	For accommodations .
85.	Charges	Total charges for this code.
86.	Non-Covered Charges	Non-covered charges for this code.
87.	Medical Record Number	Assigned by provider to patient records.
88.	Patient Control Number	Unique alphanumeric number assigned by provider for this beneficiary.
89.	Type of Admission	-Emergency -Urgent -Elective -Newborn -Unknown
90.	Source of Admission	For Admissions: -Physician referral -Clinic referral -HMO referral -Transfer from hospital -Transfer from SNF -Transfer from another health care facility
91.	Admitting Diagnosis	-Code from ICD-9-CM Volumes I and II, reason for admission, may be different than principal diagnosis.

NOTE: Items 81-86 are repeated for each revenue center code.

Home Health Agency Bill Records

	Information	Description
1.	Health Insurance Claim Number	Number that identifies the beneficiary.
2.	Beneficiary Identification Code	Identifies beneficiary's relationship to SSN. For bill and stay records this field is an equatable BIC.
3.	Cross Reference Claim Number	Beneficiary's cross-reference Health Insurance claim number.
4.	Beneficiary's Name a. Surname b. Initial - 1st c. Initial - 2nd	
5.	State Code of Residence	SSA standard State code.
6.	County Code of Residence	SSA standard county code.
7.	Date of Birth	Format YYDDD. Julian date. Date of beneficiarys birth (from Master Record).
8.	Sex Code	Code which identifies the sex of the beneficiary (from Master Record). -Unknown -Male -Female
9.	Race Code	Code which identifies the race of the beneficiary (from Master Record). -Unknown -White -Black -Other
10.	ZIP Code of Residence	Beneficiary's ZIP code from Master Record.
11.	Medicare Status Code	Indicates reason for Medicare entitlement as of a point in time. -Aged without ESRD -Aged with ESRD -Disabled without ESRD -Disabled with ESRD -ESRD only

Exhibit C

Information	Description
12. Current Reason for Entitlement	Indicates the reason for the beneficiary's current entitlement to Medicare benefits. -OASI -DIB -Renal -DIB and Renal
13. Original Reason for Entitlement	Indicates the reason for the beneficiary's original entitlement to Medicare benefits. -OASI -DIB -Renal -DIB and Renal
14. End Stage Renal Disease Indicator	This code indicates the source of the notice of end stage renal disease. -No ESRD -MBR -HI -NIH -MBR and HI -MBR and NIH -HI and NIH -MBR, HI, and NIH -Clerical -MBR and Clerical -HI and Clerical -NIH and Clerical -MBR, HI, and Clerical -MBR, NIH, and Clerical -HI, NIH, and Clerical -MBR, HI, NIH, and Clerical
15. HMO Indicator	-HMO involvement -No HMO involvement
16. Number of HMO Periods	Counter for the number of HMO periods. -Actual number of periods. -Period number nine or greater.
17. HMO Effective Date	Format YYDDD Julian start date of HMO period.
18. HMO Termination Date	Format YYDDD Julian termination date of HMO period.

	Information	Description
19.	HMO Number	Plan number for Health Maintenance Organization.
20.	HMO Option Code	For lock-in beneficiaries: -HCFA to process all provider bills. -HMO to process only in-plan Part A and in-area Part B bills. -HMO to process all Part A and Part B bills. For non-lock-in beneficiaries: -HCFA to process all provider bills. -HMO to process only in-plan Part A and in-area Part B bills.
21.	Query Code	Code indicating status of bill: -Credit adjustment -Interim bill -Final bill -Discharge bill -Discharge notice -Debit adjustment
22.	Transaction Code	Indicates the type of institutional provider. -Christian Science SNF -Psychiatric hospital -Tuberculosis hospital -General Care hospital -Regular SNF -Home Health Agency -Outpatient -Comprehensive Outpatient Rehabilitation Facility -Hospice
23.	Adjustment Code	Code indicating a cancel only bill: -Coverage transfer -Plan transfer -Scramble -Duplicate billing -Other

Exhibit C

	Information	Description
24.	Employment Related	-Complementary insurance -Employment related -Both complementary insurance and employment related -Neither complementary insurance nor employment related
25.	Provider Number	Identifier for the provider of services
26.	Record Identification Code	-Home Health Part A -Home health Part B
27.	Intermediary Number	Identification number of the intermediary processing the bill.
28.	Date Approved	Julian date bill approved by intermediary.
29.	Date Forwarded	Julian date bill received by intermediary.
30.	Date of Admission	Format YYDDD. Julian date care began.
31.	Patient Status Code	Possible Values: -Discharged -Died -Still patient -Visits exhausted
32.	Patient Status Date	YYDDD. Julian Date. Based on record with latest status date.
33.	Date of Death	Format YYDDD. Julian Date. Date of beneficiary's death as reported on the bill.
34.	Date Plan Established	Format YYDDD. Julian date. Beginning or review date of home health plan.
35.	From Date	Format YYDDD Date of first service.
36.	To Date	Format YYDDD. Julian date of last service.

	Information	Description
37.	Total Visits	Total visits for all services.
38.	Total Visit Charges	Total charges for all services.
39.	Deductible	
40.	Primary Payor Code	Information about a primary payor (with Medicare as secondary payor.) The following are the valid codes: -Working aged beneficiary/spouse with an employer group health plan -ESRD beneficiary in the 12 month coordination period with an employer group health plan -Conditional payment by Medicare; future reimbursement expected -Automobile no-fault insurance or any liability insurance -Workers' Compensation including black lung -VA, PHS, or other federal agency -Medicare is primary payor
41.	Primary Payor Amount	The amount of Medicare covered expenses paid by primary payor. Zero for Medicare.
42.	Coinsurance Amount	
43.	Number of Units	Number of units of service.
44.	Charge/Unit of Service	Dollars - Charge for each unit of service.
45.	Total Charges	Total charges for all services.
46.	Reimbursement Amount	Reimbursement amount from bill.
47.	Non-Covered Charges	
48.	Number of diagnoses	Number of diagnostic codes.
49.	Diagnosis Code	ICD-9-CM, Volumes I and II.
50.	Value Code	Description and codes are contained in the Glossary.

	Information	Description
51.	Value Code Amount	Amount related to the value code.
52.	Revenue Center Code	Code identifying each service incurred during the billing period.
53.	Units	
54.	Service Date	MMDD - May be zeroes.
55.	Rate	
56.	Covered Charges	Total charges for this code.

NOTE: Items 52-56 are repeated for each revenue center code.

Outpatient Bill Record

Information	Description
1. Health Insurance Claim Number	Number that identifies the beneficiary.
2. Beneficiary Identification Code	Identifies beneficiary's relationship to SSN. For bill and stay records this field is an equatable BIC.
3. Cross Reference Claim Number	Beneficiary's cross-reference Health Insurance claim number.
4. Beneficiary's Name a. Surname b. Initial - 1st c. Initial - 2nd	
5. State Code of Residence	SSA standard State code.
6. County Code of Residence	SSA standard county code.
7. Date of Birth	Format YYDDD. Julian date. Date of beneficiarys birth (from Master Record).
8. Sex Code	Code which identifies the sex of the beneficiary (from Master Record). -Unknown -Male -Female
9. Race Code	Code which identifies the race of the beneficiary (from Master Record). -Unknown -White -Black -Other
10. ZIP Code of Residence	Beneficiary's ZIP code from Master Record.
11. Medicare Status Code	Indicates reason for Medicare entitlement as of a point in time. -Aged without ESRD -Aged with ESRD -Disabled without ESRD -Disabled with ESRD -ESRD only

Exhibit D

Information	Description
12. Current Reason for Entitlement	Indicates the reason for the beneficiary's current entitlement to Medicare benefits. -OASI -DIB -Renal -DIB and Renal
13. Original Reason for Entitlement	Indicates the reason for the beneficiary's original entitlement to Medicare benefits. -OASI -DIB -Renal -DIB and Renal
14. End Stage Renal Disease Indicator	This code indicates the source of the notice of end stage renal disease. -No ESRD -MBR -HI -NIH -MBR and HI -MBR and NIH -HI and NIH -MBR, HI, and NIH -Clerical -MBR and Clerical -HI and Clerical -NIH and Clerical -MBR, HI, and Clerical -MBR, NIH, and Clerical -HI, NIH, and Clerical -MBR, HI, NIH, and Clerical
15. HMO Indicator	-HMO involvement -No HMO involvement
16. Number of HMO Periods	Counter for the number of HMO periods. -Actual number of periods. -Period number nine or greater.
17. HMO Effective Date	Format YYDDD Julian start date of HMO period.
18. HMO Termination Date	Format YYDDD Julian termination date of HMO period.

	Information	Description
19.	HMO Number	Plan number for Health Maintenance Organization.
20.	HMO Option Code	For lock-in beneficiaries: -HCFA to process all provider bills. -HMO to process only in-plan Part A and in-area Part B bills. -HMO to process all Part A and Part B bills. For non-lock-in beneficiaries: -HCFA to process all provider bills. -HMO to process only in-plan Part A and in-area Part B bills.
21.	Bill Covers Period	Statement covers period, Julian date.
	a. First Service b. Last service	Date of first service Date of last service
22.	Query Code	Code indicating status of bill: -Credit adjustment -Interim bill -Final bill -Discharge bill -Discharge notice -Debit adjustment
23.	Transaction Code	Indicates the type of institutional provider. -Outpatient Psychiatric Hospital -Outpatient Tuberculosis Hospital -Outpatient General Care Hospital -Outpatient SNF -Home Health Agency -Comprehensive Health Center -Clinic Rehabilitation Center -Rural Health Clinic -Satelite Dialysis Facility -Limited Care Facility -Hospice
24.	Adjustment Code	Code indicating a cancel only bill: -Coverage transfer -Plan transfer -Scramble -Duplicate billing -Other

Exhibit D

	Information	Description
25.	Employment Related	-Complementary insurance -Employment related -Both complementary insurance and employment related -Neither complementary insurance nor employment related
26.	Provider Number	Identifier for the provider of services
27.	Intermediary Number	Identification number of the intermediary processing the bill.
28.	Date Approved	Julian date bill approved by intermediary.
29.	Date Forwarded	Julian date bill received by intermediary.
30.	Patient Status Code	Possible Values: -Discharged -Died -Still patient
31.	Patient Status Date	Format YYDDD. Julian Date. Date relating to patient status code field.
32.	Date of Death	Format YYDDD. Julian Date. Date of beneficiary's death as reported on the bill.
33.	Primary Payor Code	Information about a primary payor (with Medicare as secondary payor.) The following are the valid codes: -Working aged beneficiary/spouse with an employer group health plan -ESRD beneficiary in the 12 month coordination period with an employer group health plan

	Information	Description
33.	Primary Payor Code (con.)	-Conditional payment by Medicare; future reimbursement expected -Automobile no-fault insurance or any liability insurance -Workers' Compensation including black lung -VA, PHS, or other federal agency -Medicare is primary payor
34.	Primary Payor Amount	The amount of Medicare covered expenses paid by primary payor. Zero for Medicare.
35.	Value Code	Description and codes are contained in the Glossary.
36.	Value Code Amount	Amount related to the value code.
37.	Revenue Center Code	Code identifying each service incurred during the billing period.
38.	HCPCS Procedure Code	Clinical laboratory charges for non-inpatient services reimbursed at 100 percent.
39.	Units	
40.	Service Date	MMDD - May be zeroes.
41.	Rate	
42.	Covered Charges	
43.	Professional Pathology Charges	Amount paid for hospital inpatient or other professional components.
44.	Professional Radiology Charges	Amount paid for hospital inpatient or other professional components.
45.	Professional Other Charges	Amount paid for hospital inpatient or other professional components.
46.	Blood Deductible	
47.	Blood Deductible Pints	Number of whole pints of blood
48.	Cash Deductible	
49.	Coinsurance Amount	CORF only

	Information	Description
50.	Blood Pints Furnished	Number of whole pints furnished.
51.	Blood Pints Replaced	
52.	Blood Pints Not Replaced	
53.	Blood Charge/Pint	Zero if no charge for blood. UNIBILL - Constant zero.
54.	Patient Paid for Blood Deductible	
55.	ESRD Method of Reimbursement	-Not ESRD -Method 1 -Method 2
56.	Special Service Code	-Professional component -Durable medical equipment -Home dialysis equipment -Pneumococcal vaccine
57.	Charges Excluded From Deductible	UNIBILL only, accumulation of amounts for revenue center charges which are not subject to deductible.
58.	Number of Diagnosis	Number of diagnostic codes attached.
59.	Diagnosis Code	Nature of illness code based on ICD-9-CM, Volumes I and II.
60.	Additional Diagnoses	Up to 4 additional ICD-9-CM, Volumes I and II, diagnosis codes.
61.	Date of Surgery	Format YYDDD. Date of beneficiary's surgery.
62.	Number of Surgical Procedures	Number of surgical codes.
63.	Surgical Procedure Code	Procedure codes based on ICD-9-CM, Volume III. Effective July 1, 1987 HCPCS codes replace the ICD-9-CM Volume III codes for outpatient surgery.
64.	Additional Surgery	Same as field 63. Up to two additional codes.
65.	Patient Paid Amount	
66.	Amount Paid to Provider	

	Information	Description
67.	Amount Paid to Patient	
68.	Date Benefits Exhausted	Format YYDDD. Julian date.
69.	Date Plan Terminated	Format YYDDD. Julian date.
70.	Total Charges	Total charges for all services
71.	Reimbursement Amount	Sum of amount paid to provider and amount paid to patient fields.

Exhibit E

Hospice Bill Records

	Information	Description
1.	Health Insurance Claim Number	Number that identifies the beneficiary.
2.	Beneficiary Identification Code	Identifies beneficiary's relationship to SSN. For bill and stay records this field is an equatable BIC.
3.	Cross Reference Claim Number	Beneficiary's cross-reference Health Insurance claim number.
4.	Beneficiary's Name a. Surname b. Initial - 1st c. Initial - 2nd	
5.	State Code of Residence	SSA standard State code.
6.	County Code of Residence	SSA standard county code.
7.	Date of Birth	Format YYDDD. Julian date. Date of beneficiarys birth (from Master Record).
8.	Sex Code	Code which identifies the sex of the beneficiary (from Master Record). -Unknown -Male -Female
9.	Race Code	Code which identifies the race of the beneficiary (from Master Record). -Unknown -White -Black -Other
10.	ZIP Code of Residence	Beneficiary's ZIP code from Master Record.
11.	Medicare Status Code	Indicates reason for Medicare entitlement as of a point in time. -Aged without ESRD -Aged with ESRD -Disabled without ESRD -Disabled with ESRD -ESRD only

	Information	Description
12.	Current Reason for Entitlement	Indicates the reason for the beneficiary's current entitlement to Medicare benefits. -OASI -DIB -Renal -DIB and Renal
13.	Original Reason for Entitlement	Indicates the reason for the beneficiary's original entitlement to Medicare benefits. -OASI -DIB -Renal -DIB and Renal
14.	End Stage Renal Disease Indicator	This code indicates the source of the notice of end stage renal disease. -No ESRD -MBR -HI -NIH -MBR and HI -MBR and NIH -HI and NIH -MBR, HI, and NIH -Clerical -MBR and Clerical -HI and Clerical -NIH and Clerical -MBR, HI, and Clerical -MBR, NIH, and Clerical -HI, NIH, and Clerical -MBR, HI, NIH, and Clerical
15.	HMO Indicator	-HMO involvement -No HMO involvement
16.	Number of HMO Periods	Counter for the number of HMO periods. -Actual number of periods. -Period number nine or greater.
17.	HMO Effective Date	Format YYDDD Julian start date of HMO period. Initialized to zeroes.
18.	HMO Termination Date	Format YYDDD Julian termination date of HMO period. Initialized to zeroes.

Exhibit E

	Information	Description
19.	HMO Number	Plan number for Health Maintenance Organization. Initialized zeroes.
20.	HMO Option Code	For lock-in beneficiaries: -HCFA to process all provider bills. -HMO to process only in-plan Part A and in-area Part B bills. -HMO to process all Part A and Part B bills. For non-lock-in beneficiaries: -HCFA to process all provider bills. -HMO to process only in-plan Part A and in-area Part B bills.
21.	Bill Covers Period	Statement covers period, Julian date.
	a. From Date	Beginning date of bill.
	b. Through Date	Ending date of bill.
22.	Query Code	Code indicating status of bill: -Credit adjustment -Interim bill -Final bill -Discharge bill -Discharge notice -Debit adjustment
23.	Transaction Code	Indicates the type of institutional provider. -Christian Science SNF -Psychiatric hospital -Tuberculosis hospital -General Care Hospital -Regular SNF -Home Health Agency -Outpatient -Comprehensive Outpatient Rehabilitation Facility (PATBILL only) -Hospice
24.	Adjustment Code	Code indicating a cancel only bill: -Coverage transfer -Plan transfer -Scramble -Duplicate billing -Other

Information	Description
25. Employment Related	-Complementary insurance -Employment related -Both complementary insurance and employment related -Neither complementary insurance nor employment related
26. Provider Number	Identifier for the provider of service
27. Intermediary Number	Identification number of the intermediary processing the bill.
28. Date Approved	Julian date bill approved by intermediary.
29. Date Forwarded	Julian date bill received by intermediary.
30. Date of Admission	Format YYDDD. Julian date. Date admitted to institution.
31. Patient Status Code	Possible Values -Discharged -Died -Still patient -Visits exhausted (HHA only)
32. Discharge Date	Format YYDDD. Julian date. Date of discharge from institution.
33. Date of Death	Format YYDDD. Julian Date. Date of death of beneficiary.
34. Total Covered Days	
35. Cost Report Days	Number of days which would have been Medicare covered days if another primary payer were not involved or if a beneficiary had fewer days available than were needed by a PPS bill.

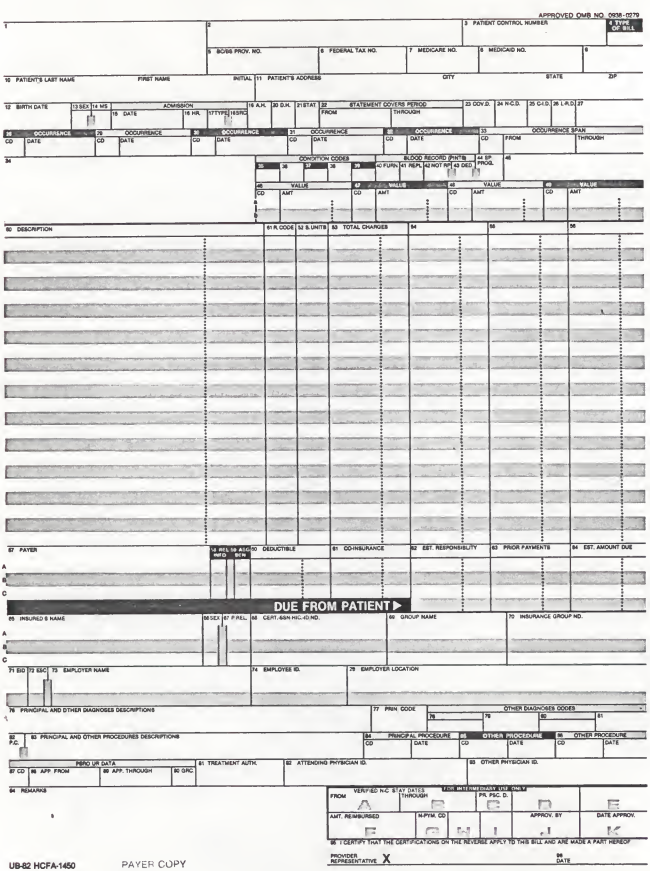
Exhibit E

	Information	Description
36.	Primary Payor Code	Information about a primary payor (with Medicare as secondary payor.) The following are the valid codes: -Working aged beneficiary/spouse with an employer group health plan -ESRD beneficiary in the 12 month coordination period with an employer group health plan -conditional payment by Medicare; future reimbursement expected -Automobile no-fault insurance or any liability insurance -Workers' Compensation including black lung -VA, PHS, or other federal agency -Medicare is primary payor
37.	Primary Payor Amount	The amount of Medicare covered expenses paid by primary payor. Zero for Medicare.
38.	Total Charges	Total charges for all accommodations and services.
39.	Reimbursement Amount	Reimbursement amount from bill.
40.	Value Code	Description and codes are contained in the Glossary.
41.	Value Code Amount	Amount related to the value code.
42.	Revenue Center Code	Code identifying each service incurred during the billing period.
43.	HCPCS Procedure Code	
44.	Units	
45.	Service Date	MMDD - May be zeroes.
46.	Rate	
47.	Covered Charges	

	Information	Description
48.	Hospice Start Date	YYDDD - From ancillary entitlement record on HDHIMA file.
49.	Stay Days	Total days for this bill (through date minus from date).
50.	Hospice Period Number	From HDHIMA file.
51.	Discharge Destination	-To home, self care -To short term hospital -To SNF -To ICF -To other type facility -To home, health service care -Left against medical advice -Still patient -Died at home -Died in a medical institution -Place of death unknown
52.	Number of Services HSP	Number of Hospice care services.
53.	Number of Diagnoses	Number of diagnostic codes.
54.	Diagnosis Code	ICD-9-CM, Volumes I and II, left justified, blank filled.

Exhibit F

HCFA-1450 (UB-82, Uniform Bill)



UB-82 HCFA-1450 PAYER COPY

V. Stay Records

Introduction

The Inpatient Hospital Stay Record contains information about a person's stay in a hospital from admission through discharge for 100 percent of Medicare enrollees. Stay records are used to compile a very large portion of the health insurance utilization statistics such as the current utilization tabulations and Medicare Provider Analysis and Review (MEDPAR) files. This record contains utilization information from bills, demographic information about the enrollee, and provider information. The file contains about 11,000,000 records per year.

Billing and Demographic Information

The basic input for the hospital stay records are bills for inpatient hospital services submitted to HCFA via intermediaries for Medicare payments by hospitals. Bills which have cleared the administrative process at HCFA and have been updated to the Health Insurance Master File (HIM) are entered into the statistical system. When the bill record is updated to the HIM, the enrollee's demographic characteristics such as age, sex, race, and State and county of residence are appended to it. The record sent for statistical processing contains both the billing information and a person's demographic characteristics. Chapter IV describes the contents of these records.

All bills submitted for the same hospital stay are sorted and summarized, creating a bill summary record. When the bill summary indicates that the patient has been discharged (i.e., a discharge bill has been received), a stay record showing information from date of admission to date of discharge is created. A single bill, in approximately 95 percent of all cases, will result in a completed stay record. If the patient has not been discharged, the bill summary remains on an orbiting bill summary file until the discharge information is received. The stay record is in the same format as the inpatient hospital and skilled nursing facility record format shown in Chapter IV, Exhibit B.

Bills used for creating stay records contain a principal diagnosis code and an indication of whether or not there were additional diagnoses. The five digit diagnostic code is assigned from the ICD-9-CM, Volumes I and II. If surgery has been performed, a principal surgical procedure code, and indication of additional surgical procedures, and a date of surgery are also shown on the bill. The four digit surgical procedure code is assigned from the ICD-9-CM, Volume III. Codes for up to four additional diagnoses and up to two additional surgical procedures may be shown. There is also a Diagnosis Related Group (DRG) number.

Provider Information

Periodically, MEDPAR records are matched to the Provider of Services file to append selected provider information. This file contains detailed information about the characteristics of each hospital participating in the Medicare program. Some of these characteristics are: location of the hospital, type of hospital, type of control, and bed size. Chapter III of this manual contains a description of the Provider of Services Master File.

SNF Stay Records

Stay records are also prepared for stays in Skilled Nursing Facilities. The SNF stay record is essentially the same as the hospital record. SNF stay records contain an admitting diagnosis instead of the principal diagnosis; and there is no surgery. The five digit admitting diagnosis code is assigned from the ICD-9-CM, Volumes I and II, as is the inpatient hospital bill principal diagnosis. There are also dates of admission and discharge of the qualifying hospital stay. The record format is the same as the inpatient hospital and skilled nursing facility record format shown in Chapter IV, Exhibit B.

Derivative Files

Exhibit A contains the contents of the MEDPAR (Medicare Provider Analysis and Review) record. The MEDPAR record is derived from the inpatient hospital stay record and the Provider of Services File, from which provider characteristics are appended to the stay record. Each record contains selected items of information from the hospital stay record. The file of MEDPAR records is prepared every 3 months and contains 3 years of discharges, the current year and 2 previous years. For example, the file created at the end of July 1986 contains discharges from 1984 through 1986. Annually, approximately 11.0 million records are created.

Exhibit B contains the contents of the MEDPAR Public Use File. This file contains selected data fields extracted from the MEDPAR records. Personal identifiers are omitted to enable use for non-HCFA purposes. The MEDPAR and the MEDPAR Public Use File are available in fiscal or calendar year format.

MEDPAR File

1.	HI Claim Number	Actual Number
2.	Age	Age as of last birthday on date of admission.
3.	Sex	Sex code obtained from HI Master Record. -Unknown -Male -Female
4.	Race	Race code obtained from HI Master Record. -Unknown -White -Black -Other
5.	Medicare Status Code	Code to show reason for beneficiary's entitlement. -Aged without ESRD -Aged with ESRD -Disabled without ESRD -Disabled with ESRD -ESRD only
6.	State and County of Residence	SSA state and county code of residence.
7.	ZIP Code of Residence	Actual code
8.	Day of Admission	Day of admission to provider. -Sunday -Monday -Tuesday -Wednesday -Thursday -Friday -Saturday
9.	Discharge Status	Discharge Status -Alive -Dead
10.	KRON Indicator	-Bill must force a new spell of illness even if it is written within 60 days of a prior spell of illness.

Exhibit A

	Information	Description
10.	KRON Indicator (con.)	-KRON indicator was submitted in a bill which was not linked to a spell of illness.
11.	PPS Indicator	Hospital being paid under a prospective payment system. -Yes -No
12.	Provider Number	Identification number of provider.
13.	Provider Code	Code to identify components of inpatient hospitals. -Original provider number as is -Psychiatric Unit -Rehabilitation Unit -Swing - Bed Hospital Designation -Alcohol Drug Unit
14.	Date of Admission	YYDDD (YY=Year, DDD=Julian Day)
15.	Date of Discharge	YYDDD (YY=Year, DDD=Julian Day)
16.	Length of Stay	Date of discharge minus date of admission. If difference was 0, it was made 1.
17.	Covered Days	The number of days covered by Medicare.
18.	Coinsurance Days	The inpatient medicare days occurring after the 60th day and before the 91st day in a single spell of illness.
19.	Coinsurance Amount	$$$$$ - Total amount for coinsurance.
20	Inpatient Deductible	$$$ - Deductible to be paid by patient.
21.	Lifetime Reserve Days Used	Under Medicare each beneficiary has a lifetime reserve of 60 additional days of inpatient hospital services after using 90 days of inpatient hospital services during a spell of illness.
22.	Total Charges	$$$$$$ - Dollars only

	Information	Description
23.	Covered Charges	$$$$$$ - Dollars only
24.	Amount Reimbursed	$$$$$$ - Dollars only
25.	Intensive Care Days	Days
26.	Coronary Care Days	Days
27.	Total Accommodation Charges	$$$$$$ - Dollars only
28.	Total Departmental (Ancillary) Charges	$$$$$$ - Dollars only (Summary Total)
29.	Intensive Care Charges	$$$$$$ - Dollars only
30.	Coronary Care Charges	$$$$$$ - Dollars only
31.	Operating Room Charges	$$$$$$ - Dollars only
32.	Pharmacy Charges	$$$$$$ - Dollars only
33.	Laboratory Charges	$$$$$$ - Dollars only
34.	Radiology Charges	$$$$$$ - Dollars only
35.	Supplies Charges	$$$$$$ - Dollars only
36.	Anesthesia Charges	$$$$$$ - Dollars only
37.	Inhalation Therapy	$$$$$$ - Dollars only
38.	Outpatient Service	$$$$$$ - Dollars only
39.	Blood Administration	$$$$$$ - Dollars only
40.	Physical Therapy	$$$$$$ - Dollars only
41.	Occupational Therapy	$$$$$$ - Dollars only
42.	Speech Pathology	$$$$$$ - Dollars only
43.	Other Charges	$$$$$$ - Dollars only
44.	Diagnostic Data	Principal and up to four additional ICD-9-CM, Volumes I and II, diagnosis codes.
	A. Number of Codes	Number of diagnostic codes.
	B. Codes	Five position diagnostic codes; left justified, blank filled.

Exhibit A

	Information	Description
45.	Surgery Indication	-Yes -No
46.	Surgical Data	
	A. Surgical Date 1	YYDDD -Date 1st surgical procedure performed. Zero if date not submitted.
	B. Number of Codes	Number of surgical codes.
	C. Codes	Four position ICD-9-CM, Volume III, surgical codes; left justified, blank filled.
	D. Surgical Date 2	YYDDD - Date 2nd surgical procedure performed. Zero if date not submitted.
	E. Surgical Date 3	YYDDD - Date 3rd surgical procedure performed. Zero if date not submitted.
47.	Blood Furnished (pints)	2-digit whole pints.
48.	Original BIC	This is the original BIC of the HIC number on the bill or payment record,which has been replaced with the equatable BIC.
49.	DRG Code	Code assigned to indicate the diagnosis related group to which this claim belongs for payment purposes.
50.	Discharge Destination	Code to indicate destination of patient at time of discharge: -To home, self care -To short-term hospital -To SNF -To ICF -To other type facility -To home, health service care -Left against medical advice -Died -Still patient
51.	Outlier Code	Code indicating whether covered days or charges exceed the threshold values. Also used to code DRG information. -No outlier -Day outlier

Information	Description
51. Outlier Code (con.)	-Cost outlier -Valid DRG received from the intermediary -HCFA developed DRG -HCFA developed DRG using Patient Status code -Not groupable
52. Primary Payor Code	Code indicating who is primarily responsible for payment. -Working aged beneficiary/spouse with employer group health plan -ESRD beneficiary in the 12 month coordination period with an employer group health plan -Conditional payment by Medicare; future reimbursement expected -Automobile no-fault or any liability insurance -Worker's Compensation including black lung -VA, PHS or other federal agency -Medicare is primary payor
53. Type of Admission	Code indicating type of Admission. -Emergency -Urgent -Elective -Newborn -Unknown
54. Source of Admission	Code indicating source of admission: -Physician referral -Clinic referral -HMO referral -Transfer from hospital -Transfer from SNF -Transfer from another health care facility -Emergency room -Court/Law enforcement -Unknown -Normal delivery -Premature delivery -Sick baby -Extramural -Unknown

Exhibit A

	Information	Description
55.	Professional Components	Dollars only - Amount for hospital inpatient or other professional components.
56.	Blood Charges	Dollars only - Charges for blood usage.
57.	Unibill Indicator	Code indicates unibill format or not unibill format.
58.	Primary Payor Amount	$$$$$$ - Dollars only. Medicare covered amount paid by primary payor. Zero filled for Medicare.
59.	Intermediary Number	Identification number of intermediary processing the bill.
60.	Payment and Edit RIC	Code indicating type of bill submitted: -HCFA-1450 -HCFA-1453 (Inpatient SNF, PIP). -HCFA-1483 (Outpatient) -HCFA-1486 (Christian Science). -HCFA-1487 (Home Health Agency) -Non-covered Bill
61.	Active Care Ended Date	YYDDD (YY=Year, DDD=Julian Day)
62.	Outlier Amount	$$$$$$ - Dollars only Additional reimbursement amount approved due to an outlier situation.
63.	Kidney Acquisition Charge	$$$$$ - Dollars only
64.	Outlier Days	Number of outlier days used.
65.	DRG Price	$$$$$$ - Dollars only
66.	New DRG Code	Grouper 3.0 (May 1, 1986-September 30, 1986). Grouper 4.0 (October 1, 1986).
67.	New Outlier Days	Number of outlier days used based on the grouper used.
68.	HI Master Date of Death	YYDDD (YY=Year, DDD=Julian Day) Date taken from the HI Master File.

	Information	Description
69.	HI Master Date of Death Indicator	-Nonvalid Date of Death -Valid Date of Death
70.	HI Master SSN Indicator	-Primary SSN -Cross Reference SSN

Exhibit B

MEDPAR Public Use File

Information	Description
1. Diagnosis Related Group (DRG)	Code assigned to indicate the DRG to which this claim belongs for payment purposes.
2. Major Diagnostic Categories (MDC)	Identifies the category of which the DRG is a member.
3. Medicare Status Code	Code indicating the reason for entitlement to Medicare benefits: -Aged without ESRD -Aged with ESRD -Disabled without ESRD -Disabled with ESRD -ESRD only
4. Day of Admission	Day of admission to provider: -Sunday -Monday -Tuesday -Wednesday -Thursday -Friday -Saturday
5. Discharge Status	Discharge Status: -Alive -Dead
6. Metropolitan/Nonmetropolitan	Codes to identify metropolitan areas designated by Statistical Area (MSA/NONMSA). Executive Office of Management and Budget (EOMB) Codes that have populations of 50,000 or greater.
7. Length of Stay	Date of discharge minus date of admission. If difference is 0, it is made 1.
8. Covered Days	The number of days covered by Medicare.
9. Total Charges	$$$$$$ - Dollars only

10.	Covered Charges	$$$$$$ - Dollars only
11.	Intensive Care and Coronary Care Days	Total of days spent in intensive care and coronary care units during this hospital stay.
12.	Total Departmental (Ancillary) Charges	$$$$$$ - Dollars only
13.	Operating Room Charges	$$$$$$ - Dollars only
14.	Pharmacy Charges	$$$$$$ - Dollars only
15.	Laboratory Charges	$$$$$$ - Dollars only
16.	Radiology Charges	$$$$$$ - Dollars only
17.	Supply Charges	$$$$$$ - Dollars only
18.	Anesthesia Charges	$$$$$$ - Dollars only
19.	Inhalation Therapy Charges	$$$$$$ - Dollars only
20.	Number of Diagnosis Codes	Number of ICD-9-CM, Volumes I and II, diagnosis codes occurring in the record.
21.	Principal Diagnosis	ICD-9-CM diagnosis code identifying the condition chiefly responsible for the patient's admission to the hospital.
22.	Diagnosis Two	Additional diagnosis.
23.	Diagnosis Three	Additional diagnosis.
24.	Diagnosis Four	Additional diagnosis.
25.	Diagnosis Five	Additional diagnosis.
26.	Surgery Indicator	Code indicating whether or not a surgery was performed. -Yes -No
27.	Number of Surgery Codes	Number of ICD-9-CM, Volume III, surgery codes appearing in the record.
28.	Principal Surgical Procedure	Surgery performed that is most related to the principal diagnosis.
29.	Surgery Two	Additional surgery.

30.	Surgery Three	Additional surgery.
31.	Age	Age as of last birthday on date of admission.
32.	Sex	Sex of the beneficiary. -Unknown -Male -Female
33.	Blood Pints Furnished	Number of pints of blood or packed red cells furnished whether or not replaced.

VI. Part B Payment Records

Introduction

Part B Supplementary Medical Insurance (SMI) benefits are payable for physician's services, home health service visits, outpatient hospital services, and other medical services and supplies. Medical insurance benefits for home health services and outpatient hospital services, where the bills are processed by a Part A intermediary, are covered in other chapters. This chapter relates to physician services and other medical services and supplies where the requests for payment are processed by Part B carriers. Payments are generally made on a charge basis and are generally subject to both an annual deductible amount and a coinsurance amount. Specific medical services not subject to any deductible or coinsurance amounts are detailed in the "Preparation of the Payment Record" portion of this chapter. Payments for services can be made directly to a physician (or other supplier of medical services) if they accept assignment or to the beneficiary if assignment is not accepted by the physician or supplier. Basically Forms HCFA-1500/1490S are the basic Part B claim forms used by either the patient or physician (supplier) to claim reimbursement. (Form HCFA-1490 was used prior to Forms HCFA-1500 or HCFA-1490S).

HCFA, which has the basic responsibility for administering the SMI program, enters into agreements with public or private organizations which serve as carriers to help administer the medical insurance benefit claims process. These contractor organizations, using HCFA coverage and claims processing guidelines, determine which services are covered, the amounts payable, and make payment to providers and beneficiaries. They also communicate utilization and benefit information to HCFA.

Carriers prepare and send to HCFA a payment record for every bill for which reimbursement is made under the Supplementary Medical Insurance Program. The payment record has very important administrative and statistical uses.

1. To provide current information on supplementary medical insurance benefit payments and to make possible the preparation of a variety of operating statistics.

2. To provide information to assist in the conduct of administrative and fiscal audits of carrier operations.

3. To draw samples for special ad hoc studies focusing on specific groups of physicians and suppliers, specific types of services, and specific geographic areas.

4. To provide current information to assist in preparing a variety of program statistics tabulations.

5. To provide a 100 percent base from which either samples or 100 percent files may be used to provide data needed for actuarial calculations.

Because of their importance, all carriers prepare payment records uniformly in accordance with the instructions contained in the Medicare Carrier's Manual and transmit them promptly to HCFA.

The Office of Health Program Systems (OHPS) handles the automated processing of payment records and has the responsibility to determine the appropriateness of payments made by carriers based on a computer analysis of the data contained in the

payment records and the related Health Insurance Master Record data. Entitlement to benefits during the period in which expenses were incurred, deductible satisfied, proper computation of the reimbursable amount, etc., are monitored in the data edit/validation processes. Inconsistencies detected are returned to the carriers for investigation, correction, and resubmission. A "suspense" file of all rejected records is maintained by OHPS to ensure their return. As these records are corrected and returned, they are deleted from the suspense file and processed in the utilization routines.

Preparation of the Payment Record

A payment record is prepared by a carrier after the amount of reimbursement on an individual bill has been determined and payment has been made to the physician or the beneficiary (or on his or her behalf). A "bill" is defined as a request for payment from a beneficiary accompanied by one or more itemized statements from a single physician or single supplier. A payment record is submitted for every bill for which reimbursement is made. Payment records are also prepared for bills where the primary payor is other than Medicare. Situations will arise--e.g., overpayments or incomplete information--where carriers determine that the amount reimbursed for a specific bill is incorrect and needs to be adjusted. In those instances, a corrected payment record is submitted.

The number of bills on a request for payment is determined by the number of different beneficiary-physician (or supplier) relationships represented. For example, a request for payment accompanied by itemized statements from only one physician or supplier constitutes only one bill, regardless of the number of occasions of service. A request for payment accompanied by itemized statements from two physicians or suppliers constitutes two bills, etc.

The definition of a payment record is generally the same as that of a bill. A request for payment from a beneficiary accompanied by one or more itemized statements from the same physician requires preparation of only one payment record. On the other hand, if a beneficiary had accumulated and submitted itemized statements from two physicians for medical treatment and from an orthotist for fitting and purchase of an artificial leg and reimbursement was made for the services of all three, the carrier prepares three payment records--one for each physician's services and one for the orthotist's services.

Separate payment records are prepared when a bill is submitted for services rendered in different calendar years in each of which the deductible had been met and reimbursement made.

Separate payment records are also prepared for bills submitted covering specific services requiring special payment procedures designated by Amendments to the Medicare Law. These services include:

1. Hospital-based Radiologist and Pathologists

   Effective October 1, 1982, inpatient radiology and pathology services became reimbursable on the same basis as for other physician services, i.e., 80 percent of the reasonable charge after the Part B deductible has been met.

   Prior to October 1982, Medicare reimbursed these services at 100 percent of reasonable charges with no deductible or coinsurance applied.

2. Diagnostic Laboratory Fees Reimbursed at a Negotiated Rate

Beginning June 30, 1984, services performed in a laboratory that are billed on an assignment basis may be reimbursed at 100 percent of a negotiated rate with no coinsurance applied; however, payments made are subject to the annual deductible. This applies only to those laboratories which have negotiated a rate agreement with the carrier.

3. Independent Physical Therapists

Beginning July 1, 1973, services performed by an independent physical therapist in the therapist's office or in the patient's home became covered up to a maximum of $100 a year. This was increased to $500 a year effective January 1, 1982. A separate payment record is prepared for each bill for services performed by an independent therapist until the maximum expense has been incurred.

4. Physician Services Provided to Living Kidney Donors

Beginning October 1, 1978, physician services provided to living kidney donors are reimbursed at 100 percent. These services include monies for both the kidney donation surgery and the post-operative recovery period. These services are billed to the program under the name and HI Claim Number of the recipient.

5. Used Durable Medical Equipment (DME)

Beginning November 1, 1977, the purchase of used DME became reimbursable at 100 percent of the reasonable charge less any deductible yet to be met. The used DME charge, however, cannot exceed 75 percent of the cost of new DME.

6. Pneumococcal Vaccine

Effective July 1, 1981, carriers were authorized to reimburse beneficiaries/physicians 100 percent of the reasonable charge of the cost and administration of pneumococcal vaccine. Both deductible and coinsurance will be waived for this service.

7. Ambulatory Surgical Center

Beginning September 7, 1982, certain services performed in an Ambulatory Surgical Center or in a hospital outpatient setting that are billed on an assignment basis may be reimbursed at 100 percent of the reasonable charge. Reimbursement in this manner is not subject to the deductible or coinsurance.

NOTE: Although separate payment records are prepared for the above types of service, the beneficiary, physician, and calendar year relationship must still exist in all payment records produced.

Whenever payment is made for purchase of durable medical equipment, a payment record is also prepared. If the payments are spread out over a period of months, a payment record is also prepared for each payment even though monthly bills are not submitted.

The 1967 Amendments established, effective January 1, 1968, a separate Part B blood deductible. This deductible is equal to the charge for the first three (3) pints of blood furnished an individual in a calendar year. When a Request for Payment is received for blood charges, no payment record is prepared if those charges represent blood used to satisfy the Part B blood deductible. Charges for blood after the blood deductible has been satisfied and for which payment is made requires the preparation of a payment record.

Deviations are not made from the procedures discussed above for preparing payment records on a "bill" basis. In addition, the format of the payment records and codes to be used for individual fields must conform exactly to those detailed in Exhibit A.

Contents of the Payment Record

For purposes of this manual, a description of payment records used in statistical programs is available in Exhibit A. Carriers code all fields, using the same coding criteria and periodically submit records on magnetic tape. Each record contains beneficiary and physician identification with reasonable charges and reimbursement amounts. Statistical data includes type and place of service, specialty code of the physician/supplier, and month and year of service.

Approximately 175 million payment records are received annually.

Payment Record Contents

Information	Description
1. HI Claim Number	Beneficiary's Health Insurance claim number.
2. ZIP Code of residence	Actual
3. Entry Code	A code for type of payment record being submitted: -Original debit -Supplemental debit -Full credit -Partial credit -Replacement debit -Partial debit
4. Entry Recode	-Initially submitted, accepted records -Resubmitted accepted records -Initially submitted, rejected records -Resubmitted rejected records -Acknowledge an A reject previously submitted
5. Beneficiary's Name a. Surname b. First Initial	
6. Medicare Status Code	Beneficiary's Status: -Aged without ESRD -Aged with ESRD -Disabled without ESRD -Disabled with ESRD -ESRD only
7. Physical Therapy Indicator	-No physical therapy involvement -Physical therapy involvement
8. Receipt Date-HCFA	Julian date of receipt into the EDP system.
9. Original Reason for Entitlement	-OASI -DIB -Renal -DIB and Renal
10. End Stage Renal Disease Indication	-MBR notice of ESRD -HI notice of ESRD

Exhibit A

Information	Description
10. End Stage Renal Disease Indication (con.)	-NIH notice of ESRD -MBR and HI notice of ESRD -MBR and NIH notice of ESRD -HI and NIH notice of ESRD -MBR, HI, and NIH notice of ESRD
11. Carrier Bill Dates	
a. Date Bill Received	Julian date the bill is received by carrier.
b. Date Bill Paid	Julian date carrier indicates on the benefit check. Where the carrier makes payment to physicians on a periodic basis through pre-arrangement, the date paid reflects the date the carrier would have ordinarily prepared the check if the physician were not reimbursed on a periodic basis.
12. Carrier Number	Unique identification number assigned by HCFA.
13. Expense Dates	Period for which expense incurred.
First Expense Date	-Indicates year and first Julian day of the month in which expense period began.
Last Expense Date	-Indicates year and first Julian day of the month in which expense period ended.
14. Outpatient Psychiatric Charges	The outpatient Psychiatric expense represents 62½ percent (or $312.50, whichever is less) of the reasonable psychiatric charges for the items on the Request for Payment Form for which payments have been made.
15. Reimbursement Amount	The amount of payment made to or on behalf of the beneficiary.
16. Carrier Batch Number	
a. Batch Year	-Unit position of the year in which batch was created.
b. Batch Month	-Month in which the batch was created.
c. Batch Sequence Number	-Payment batches

Information	Description
16. Carrier Batch Number (con.)	-Correction batches
17. Current Reason for Entitlement	-OASI -DIB -Renal -DIB and Renal
18. Reasonable Medical Charges (Non-psychiatric)	The reasonable charges for the non-psychiatric items on the Request for Payment form for which payment has been made. NOTE: Payment records submitted for payment of services of an independent physical therapist contain a "p" in the high order position of this field.
19. Deductible Applied	Amount of incurred expenses in this record which were applied to the deductible. All nines in field indicate 100 percent reimbursement.
20. Carrier Control Number	Unique control number assigned each payment record by carrier.
21. Control Number Check Character	Assigned by HCFA to ensure unique control for identification of each payment record.
22. Physician or Supplier Identification Code	The number used to identify each individual physician, group, clinic or medical supplier, ambulance service, clinical laboratory, medical supply house, etc. Social Security Account Numbers are to be used for solo-practice physicians and sole-proprietorship suppliers where the request for payment is reimbursed on a fee for service basis. Employer Identification (EI) Number The EI number is to be used when identifying groups, partnerships, or clinics. EI numbers are also used for independent laboratories, group practice prepayment plans, and

Exhibit A

Information	Description
22. Physician or Supplier Identification Code (con.)	other entities who bill in a group or company's name including physicians billing through a provider as hospital-based physicians. Other Identification Numbers Unique identification numbers assigned by the carriers are to be used if the social security or employer identification number is not available. Such usage should be very limited and occur only until valid Social Security or EI numbers can be obtained. NOTE: Vendors providing services outside the U.S. are assigned a unique number also. (The provider number assigned by HCFA or, if none available, a carrier assigned number).
23. Number of Separate Charges	A count of the number of separate covered charges which the carrier has taken into consideration when making the reasonable charge determination. When a series of similar services are represented by an inclusive single charge, each occasion of service is counted as a separate charge. Ninety-nine is used for 99 or more separate charges.
24. Place of Service	Place of service is based on the item with largest single charge on the bill: -Office -Home -Inpatient hospital -SNF/Nursing Home -Outpatient hospital -Independent laboratory -Independent Kidney Disease Treatment Center -Ambulatory Surgical Center

Information	Description
24. Place of Service (con.)	-Other
25. Type of Service	Type of service is based on the items with the largest single charge on the bill: -Medical care -Surgery -Consultation -Diagnostic X-Ray -Diagnostic laboratory -Radiation therapy -Anesthesia -Assistance at surgery -Other medical service, including durable medical equipment -Charges for whole blood or packed red blood cells -Purchase of used DME (Effective 11/77) -Surgical second opinion (Effective 03/78) -Surgical third opinion (Effective 03/78) -Alternate payment method for maintenance dialysis -Live kidney donor -ASC Facility Usage -Renal supplies in the home -Pneumococcal vaccine The following are definitions of type of service used in assigning the codes listed above: Medical Care - Includes all physician services, including podiatrists and surgical chiropodists not elsewhere classified, and covers office visits, home visits, nursing home visits, and nonsurgical hospital visits. Psychiatric services, diagnostic services, allergy testing, therapeutic procedures, special dermatological procedures, and physical medicine services are also included. Consultation is excluded. Surgery - Includes those procedures recognized in the surgical section of Current Procedural Terminology published by the AMA and covers

Information	Description
25. Type of Service (con.)	services pertaining to incision, excision, repair, suture, destruction, introduction, fractures, manipulation, dislocations, amputation, and endoscopy.
	Consultation - Refers to the professional service rendered by a physician whose opinion or advice has been requested by another physician or agency for the evaluation and/or treatment of a patient.
	Diagnostic X-Ray - X-Ray and related services undertaken for diagnostic purposes. Includes portable X-Ray services after 12/31/67.
	Diagnostic Laboratory - Laboratory services, regardless of where rendered, required in the diagnosis of disease or injury. Also includes certain mechanical or machine tests such as EKG, EEG, BMT, etc.
	Ultrasound diagnostic procedures performed after 12/31/74 are also shown under this code.
	Radiation Therapy - Therapeutic services, such as X-Ray, radon, radium, and isotopes for the treatment of malignancies, tumors of bones, brain, or spinal cord, angiomas, vascular nevi, lymphomas leukemia, and thyroid disease.
	Anesthesia - Services for anesthesia including the appropriate pre-and post-operative visits, administration of anesthetic, and transfusion of fluids and/or blood incident to the anesthesia or surgery.

Information	Description
25. Type of Service (con.)	Assistance at Surgery - Surgical assistance rendered upon the request of the primary surgeon and governed by the rules for such service prescribed by the carrier.
	Other medical services - Services falling in the following special categories:
	-Rental of durable medical equipment
	-Purchase of durable medical equipment after 12/31/67
	-Ambulance service
	-Internal and external prosthetic devices and appliances
	-Supplies
	Charges for Whole Blood or Packed Red Blood Cells - Includes bills where the charges are for whole blood or packed red blood cells and where reimbursement is made.
	Purchase of Used Durable Medical Equipment - Effective November 1977, carriers were authorized to reimburse beneficiaries/suppliers 100 percent of the reasonable charges for purchase of used DME if such charge does not exceed 75 percent of the cost of new DME (deductible must still be met).
	Surgical Second Opinion -Effective March 1978, carriers are authorized to pay claims for patient-initiated second physician options pertaining to the medical need for surgery. Beneficiaries are responsible for applicable

Exhibit A

Information	Description
25.Type of Service(con.)	deductible and coinsurance amounts.
	Surgical Third Opinion - Effective March 1978, carriers are also authorized to pay claims for patient-initiated, third physician opinions pertaining to the medical need for surgery. As in type of service Y, beneficiaries are responsible for applicable deductibles and coinsurance amounts. Third opinion requests may occur if the initial and second physician opinions differ regarding the medical need for such surgery.
	Alternate Payment Method for Maintenance Dialysis - Effective July 1975, physicians may elect to be paid on a monthly basis for all services rendered to maintenance dialysis patients.
	Physicians Services Provided to Living Kidney Donors - Effective October 1978, carriers were authorized to pay claims for physician services rendered to obtain kidney from a living donor. Services include monies for both the kidney donation surgery and post operative recovery period. These claims are paid under the name and HI claim number of the recipient.
	ASC Facility Usage - Effective September 1982, carriers were authorized to reimburse Ambulatory Surgical Centers for 100 percent of their cost of facility usage for Medicare beneficiaries.
	Renal Supplies in the Home - Cost of supplies used in the beneficiary's home in the treatment of end stage renal disease.
	Pneumococcal Vaccine - Effective July 1, 1981, carriers were

Information	Description
25. Type of Service (con.)	authorized to reimburse beneficiaries/physicians 100 percent of the reasonable charge of the cost and administration of pneumococcal vaccine.
26. Type of Physician or Supplier ID Number	-Physician or suppliers billing as solo-practitioners for whom SS numbers are shown in the physician ID code field.
	-Physicians or suppliers billing as solo-practitioners for whom SS numbers are not available and the carrier's own physician ID code is shown.
	-Suppliers (other than sole proprietorship) for whom employer identification numbers are used in coding the ID field.
	-Suppliers (other than sole proprietorship) for whom employer ID numbers are not known and the carrier's own code has been shown.
	-Hospitals (including hospitals billing for hospital-based physicians) and independent laboratories for whom EI numbers are used in coding the ID field. Hospitals include HHA & SNF providers.
	-Hospitals (including hospitals billing for hospital-based physicians) and independent laboratories for whom EI numbers are not available and provider numbers assigned by HCFA are shown. Hospitals include HHA & SNF providers.
	-Clinics, groups, associations, or partnerships for whom EI numbers are used in coding the ID field.
	-Group practice prepayment plans for whom EI numbers are used in coding the ID field.

Exhibit A

Information	Description
26. Type of Physician or Supplier ID Number (con.)	-Clinics, groups, associations, partnerships, or GPPP's for whom EI numbers are not available and therefore the carrier's own physician code has been assigned.
27. Payment Code	A code indicating whether the payment being recorded was made to the beneficiary, to the physician or supplier, to both (partial payment to both the beneficiary and the physician or supplier on the same bill), or to a provider where the provider bills for the physician. -For payment to physician or supplier -For payment to beneficiary -For partial payment to both -For payment to hospital (hospital-based physicians) -For partial payment to both hospital and beneficiary -For payment to group practice prepayment plan -For payment to all federally funded entities -For payment to other entities, e.g., employer, union NOTE: a. If a beneficiary is deceased and payment would have been made to him or her alive, payment to beneficiary is indicated. b. Payment codes indicating payments to hospitals also include nursing facilities, or home health agencies where payment for the physicians' services are made directly to the facility.

Information	Description
28. Physician or Supplier Speciality Code	A two-digit code for each physician or supplier indicating the physician's major speciality or type of supplier. See Exhibit B. The clinic specialty code (70) should be used only where all of the following conditions are met: (1) The association consists of physicians with mixed (more than one) specialties. (2) Charges are uniform for a medical procedure regardless of the individual physician performing the services. (3) The request for payment is submitted in the name of the association and not the physician who performs the service. An association of two or more physicians may be considered a group (other than clinic) if both (2) and (3) above are met and the physicians involved are all one specialty. The group should be assigned the code applicable to that specialty.
29. Region Code	Reflects the region of the carrier recording the payment. -Boston -New York -Philadelphia -Atlanta -Chicago -Dallas -Kansas City -Denver -San Francisco -Seattle -Railroad Board -Social Security
30. Exception Code	Indicates reason for payment record reject:

Information	Description
30. Exception Code (con.)	-Record accepted -Name/Number exception. -Beneficiary never entitled to Part B -Payment record does not crossfoot -Invalid month of expense -No entitlement in the month of expense -Last month of expense is later than beneficiary month of death (one month tolerance) -Deductible not satisfied -Deductible in payment record exceeds $50 or $60 -Invalid entry code -Blood charges with no previous query containing blood -Radiology/Pathology or Diagnostic Lab testing -Psychiatric monies exceed the maximum -Physical therapy reject -Physical therapy monies exceed the maximum -HMO lock-in
31. State Code of Residence	
32. County Code of Residence	
33. Date of Birth	Julian date of beneficiary's birth.
34. Sex	-Male -Female -Unknown
35. Race	-White -Black -Other -Unknown
36. Primary Payor	Denotes the primary payor for this bill. -Working Aged Beneficiary/Spouse -ESRD Beneficiary with Employer Group Health Plan -Any conditional payment situation

Information	Description
36. Primary Payor (con.)	-No-Fault auto or liability insurance -Workmans compensation/black lung -Veterans Administration -Medicare

Exhibit B

Physician and Supplier Specialty Codes

For each request for payment involving physicians' services, carriers code the specialty of each physician rendering services. The 2 digit codes used are:

Code	Physician Specialization
01	General Practice
02	General Surgery
03	Allergy
04	Otology, Laryngology, Rhinology
05	Anesthesiology
06	Cardiovascular Disease
07	Dermatology
08	Family Practice
09	Gynecology (Osteopaths only)
10	Gastroenterology
11	Internal Medicine
12	Manipulative Therapy (Osteopaths only)
13	Neurology
14	Neurological Surgery
15	Obstetrics (Osteopaths only)
16	OB - Gynecology
17	Ophthalmology, Otology, Laryngology, Rhinology (Osteopaths only)
18	Ophthalmology
19	Oral Surgery (Dentists only)
20	Orthopedic Surgery
21	Pathologic Anatomy; Clinical Pathology (Osteopaths only)
22	Pathology
23	Peripheral Vascular Diseases or Surgery (Osteopaths only)
24	Plastic Surgery
25	Physical Medicine and Rehabilitation
26	Psychiatry
27	Psychiatry, Neurology (Osteopaths only)
28	Proctology
29	Pulmonary Diseases
30	Radiology
31	Roentgenology, Radiology (Osteopaths only)
32	Radiation Therapy (Osteopaths only)

Physician and Supplier Speciality Codes (con.)

Code	Physician Specilization
33	Thoracic Surgery
34	Urology
35	Chiropractor, licensed (effective July 1973)
36	Nuclear medicine
37	Pediatrics
38	Geriatrics
39	Nephrology
40	Hand Surgery
41	Optometrist-effective July 1, 1981 (services related to condition of aphakia)
48	Podiatry - Surgical Chiropody
49	Miscellaneous
70	Clinic or other group practice, except GPPP (see note below)
99	Unknown

Individual physicians are considered specialists if they consider themselves specialists and so classify themselves regardless of whether or not they are certified by specialty boards or eligible for certification. For physicians with more than one specialty, the carrier enters the major specialty of the physician on all his or her payment records and does not vary the specialty code with the different types of service reported for that physician.

NOTE: Use of code "70" above. Clinic code "70" is used:

(a) only where charges are uniform for a medical procedure regardless of the individual physician in the group or clinic performing the service; and

(b) only for those groups composed of physicians with mixed (two or more) specialties; and

(c) only where the request for payment does not identify the performing physician but is submitted in the name of the group.

Groups whose physician members are all one specialty should be assigned the code applicable to that specialty. Specialty code "70" should not be used for such groups.

NOTE: Specialty code use for services in an independent laboratory:

When a physician ordering tests or x-rays submits a request for payment for services performed in an independent laboratory, the physician's specialty code will be shown. If the independent laboratory submits the request, then "type of supplier code 69" is shown.

Coding Type of Supplier--Requests for payment involving services by suppliers other than physicians are coded with a type of supplier code as shown below.

Code	Type of Supplier
51	Medical supply company with CO (Certified orthotist certified by American Board for Certification in Prosthetics and Orthotics) certification
52	Medical supply company with CP (Certified prosthetist certified by American Board for Certification in Prosthetics and Orthotics) certification
53	Medical supply company with CPO (Certified prosthetist-orthotist certified by American Board for Certification in Prosthetics and Orthotics) certification
54	Medical supply company not included in 51, 52, or 53
55	Individual CO
56	Individual CP
57	Individual CPO
58	Individuals not included in 55, 56, or 57
59	Ambulance service supplier, e.g., private ambulance companies, funeral homes, etc.
60	Public Health or Welfare Agencies (Federal, State and local)
61	Voluntary Health or Charitable Agencies (e.g., National Cancer Society, National Heart Association, Catholic Charities, Inc., etc.)
62	Psychologist (Billing Independently)
63	Portable X-Ray Supplier (Billing Independently)

Coding Type of Supplier (con.)

64	Audiologists (Billing Independently)
65	Physical Therapist (Independent Practice) (July 1973)
69	Independent Laboratory (Billing Independently)
87	All other e.g., Drug and Department Stores
88	Unknown

Coding Type of Service for Group Practice Prepayment Plans

The following codes are used to code type of service only for bills submitted by group practice prepayment plans on Form HCFA-1556. These codes are used only for services that do not involve a "visit" to a physician. A "visit" to a physician is defined as a formal face-to-face contact between the physician and the patient for purposes of diagnosis or treatment. For bills involving a "visit" to a physician, the specialty of the physician providing services is coded using the physician specialty codes.

Code	Type of Service
71	Diagnostic X-Ray
72	Diagnostic Laboratory
73	Physiotherapy
74	Occupational Therapy
75	Other Medical Care

VII. Part B Medicare Annual Data (BMAD)

Introduction

The files of data collected in central office prior to May 1984 did not provide all the Part B data necessary to satisfy HCFA's needs. Therefore, additional files were developed to be submitted by carriers annually that would supplement available data. Carriers were required to extract these data from their claims processing history for Medicare claims only.

The BMAD Data is provided in four separate files:

A. Procedure File - Provides an array of every procedure processed showing the related frequency, submitted charge and paid amount. This gives HCFA detail on the services processed by carriers. Exhibit A

B. Prevailing Charge File - Provides HCFA with prevailing charge limits for each service contained in the Procedure File. This allows HCFA to study and accurately project payment levels. Exhibit B

C. Provider File - Contains line by line detail from claims history of procedures rendered by a sample of physician/suppliers. This allows HCFA to study the impact of actual and projected program changes on them. It allows HCFA to conduct longitudinal analyses of practice trends. For 1983 and 1984, a one percent sample was required. Starting with 1985, the sample size was increased to five percent of active physicians/suppliers. Exhibit C

D. Beneficiary File - Contains line by line detail from claims history of services received by all ESRD Beneficiaries and a five percent sample of other beneficiaries. This allows HCFA to link, based upon the Health Insurance Claim Account Number (HICAN), a beneficiary's Part B service utilization data with the Part A service utilization data that exists in other central office files. Exhibit D

The Office of Statistics and Data Management, HCFA, receives all BMAD Records directly and processes them through a series of edit and validation programs. Files that can not be read or fail critical edits are returned for correction. All records passing the initial edits and containing HCFA Common Procedure Coding System (HCPCS) codes are then processed into "Master Files."

For the Procedure, Provider and Beneficiary files, the data are produced and submitted from Medicare claims history for services rendered in the preceding calendar year. For the Prevailing Charge File, the data reflects history for services used in developing the prevailing charge screens. Data are provided in the HCFA specified formats. Data definitions are consistent with the existing definitions for other HCFA submittals whenever they apply.

BMAD Interactive Systems

The BMAD System consists of three basic modules and provides users the capability to access the data files interactively. Only users having an existing user ID/password may access these subsystems directly.

Receipt and Control Subsystem

This module enables the user to obtain timely information on the status of individual carrier's submittals. Additionally carrier totals, by file, are available that provide overall totals of charges, number of records, etc. The Receipt and Control Subsystem is maintained on a calendar year basis.

Data Limitations Subsystem

This module provides edit and validation results by file and carrier. Each file will have a general limitation statement followed by individual carrier panels containing information pertinent to each of the files. These limitation statements should be used in conjunction with results the users may obtain from manipulating the BMAD data through the Extract Subsystem on any customized programs.

User Extract Subsystem

The User Extract Subsystem creates four master files, one for each category of data. Information from these master files is extracted and summarized to create 22 user files. The four master files are not directly accessible by the user. Requests for such access should be directed to BDMS/OSDM.

The contents of these user files are determined from the results of an annual user survey. User files are designed to cover the most likely uses of the BMAD data. Each file contains an extract from and/or summary of the BMAD data base. The creation of some of these files requires the use of parameters stored in the classification criteria tables. These user files are expected to meet a large majority of all user requirements from the BMAD System, and hence, assume an important role in the system.

A User Manual describes the methods and procedures available to the BMAD user community for accessing the information contained in these 22 user files. It also includes an overview of the files and an explanation of major data elements.

The following features are found in common throughout the user files:

- Only HCPCS Procedure Codes are extracted.
- Only records which contain no errors in fields of interest are considered for retrieval.

Contents of the BMAD Record

The BMAD record, for each file, is a fixed length record submitted on magnetic tape and contains information associated with the specific file.

Procedure File

This file provides calendar year data on procedure codes. This is an array of every procedure code used by each carrier. The array is in locality, specialty code, type of service, place of service and ascending order of procedure/modifier codes. Every code contained in the preceding calendar year history, even if the code was used only once, is shown.

Procedure File

Information		Description
1.	Locality	This two digit code identifies the pricing locality used.
2.	Specialty	The HCFA 2-digit code showing the type of specialty of the physician/supplier providing the service.
3.	Procedure Code	The 5-digit HCPCS code as recorded in carrier history or converted history.
4.	Modifier	The HCPCS 2-digit modifier. If multiple modifiers are reported, 99 is shown.
5.	Place of Service	This field denotes the place of service. -Office -Home -Inpatient Hospital -SNF -Outpatient Hospital -Independent Laboratory -Other -Independent Kidney Disease Treatment Center -Ambulatory Surgery Center -Hospice
6.	Type of Service	This field represents the type of service. -Medical Care -Surgery -Consultation -Diagnostic X-Ray -Diagnostic Laboratory -Radiation Therapy -Anesthesia -Assistance at Surgery -Other Medical Service -Whole Blood or Packed Red Cells -Used DME -Ambulatory Surgical Center (Facility Usage)

Exhibit A

Information	Description
6. Type of service (con.)	-Renal Supplier in the Home -Monthly Capitation Payment (Dialysis) -Kidney Donor -Pneumococcal Vaccine -Second Opinion on Elective Surgery -Third Opinion on Elective Surgery
7. Frequency	An unduplicated count of the total number of times that this procedure code/modifier occurred within this locality, specialty, T/S, P/S sequence as reported by or on behalf of, a beneficiary. Duplicates or adjustments to initial line items are not included.
8. Miles/ Time/ Unit / Services	The total number of miles (or units) used in calculating reimbursement for covered transportation, or
(MTUS)	the total number of anesthesia units used in calculating reimbursement for covered anesthesia services, or
	the total number of units (pts.) of blood reimbursed, or
	the number of services used in calculating reimbursement amounts for covered physician/supplier services.
9. MTUS Indicator	-The MTUS represents only time, miles, or units.
	-The MTUS includes other values such as base units.
	-The MTUS represents services.
10. Submitted Charges	Total of submitted charges from all line items for this service included in the Frequency Field rounded to nearest dollar.

Information	Description
11. Allowed Charges	Total of all allowed charges from all accepted line items (including deductible) for this service and then rounded to nearest dollar.
12. Filler	Blanks
13. Denied Frequencies	The number of times that the frequency counted in the Frequency field has been denied in full because: claimant ineligible, filing limitations exceeded, services not covered, or services not medically necessary. Duplicates or adjustments are not included.
14. Amount Denied	Total of the submitted charges from all line items shown in Denied Frequency field and rounded to nearest dollar.
15. Edit Exclusions	The total number of frequencies that represent adjustment actions, duplicate bills or other types of actions that are not included in Frequency field.
16. Amount of Exclusions	The dollar value of the submitted charge for all services in Edit Exclusion field above rounded to nearest dollar.
17. Services Assigned	The number of times the frequency shown in Frequency field was provided on assignment.

Exhibit B

Prevailing Charge File

This file provides charge data generated by each carrier for each service during the Reasonable Charge update process.

Information		Description
1.	Locality	This 2-digit code identifies the pricing locality used.
2.	Specialty	The specialty code used for profile development. Either the HCFA 2-digit code which shows the specialty for the physician/supplier providing the service, or the specialty code used for profiling may be shown.
3.	Type of Service	This field represents the type of service. Use the codes defined in the Procedure File for the Type of Service code used for profiling.
4.	Procedure Code	The 5-digit HCPCS code for every service recorded on this file.
5.	Modifier	Only the modifiers that result in a separate prevailing charge are shown.
6.	Relative Value	Any of the following: -Relative Value Unit (RVU), or -Relativity not Established, or -By Report, where individual consideration is used to price the service.
7.	Conversion Factor	The Prevailing Charge conversion factor (CF) that is appropriate for this service.
8.	50%	The 50th percentile value calculated for this service.
9.	75%	The unadjusted prevailing charge for this locality and specialty that was calculated for this service.
10.	Origin	The origin of the data used to calculate the 75 percent unadjusted prevailing charge.

Information		Description
10.	Origin (con.)	-75 percent was "N/A" -Medicare data only -Private business and Medicare -Other data -Private business only -Medicaid only -Medicare and Medicaid -Medicare, Medicaid, and private business
11.	Gap Fill Prevailing Charge	Coded only if unadjusted prevailing charge (75%) does not contain a calculation, the gap-fill unadjusted prevailing charge which will be used in the claims processing sequence. Where insufficient data exists to calculate a value, "RVU" is shown.
12.	Source of Gap Fill	Coded to indicate source: -No Gap fill prevailing charge -Carrier wide/by specialty -Locality/no specialty -Carrier wide/no specialty -Array of actual charges -Other calculated value -"RVU" shown in Gap Fill Prevailing charge to reflect that insufficient data are available to calculate a value. -Unknown
13.	Adjusted 75% (Prevailing charge) (Participating Physicians and Suppliers)	The numeric value of the prevailing charge that will be used for payment determination, i.e., the actual unadjusted prevailing charge, the Economic Index (EI) adjusted prevailing charge or another screen value, whichever is less.
14.	Source of Adjustment (Participating Physicians and Suppliers)	The source of the value shown in adjusted 75 percent participating physicians. -No charge adjustment was made to the prevailing charge or no prevailing charge value was calculated. -EI adjustment -Lowest charge adjustment -No roll back adjustment

Exhibit B

Information	Description
14. Source of Adjustment (con.)	-Price list -Inherent reasonableness -Laboratory charge disposition - Lab fee schedule -Other -Comparability
15. Adjusted 75% (Prevailing charge) (Non-participating Physicians)	The numeric value of the prevailing charge that will be used for payment determination, i.e., the actual unadjusted prevailing charge, the prior year prevailing charge applicable to nonparticipating physicians, or another screen value, whichever is less.

Provider File

This file provides data for all services rendered by selected physicians/suppliers. Prior to the 1985 submittals, the sample size was a one percent sample of all active physician/suppliers in a carrier's service area. For 1985 and later, the sample size was increased to five percent of those active in the calendar period, i.e., January through December. The sampling techniques were developed by HCFA and all physicians/suppliers initially selected must be retained and reselected in subsequent years if they are currently active.

Information		Description
1.	Provider ID Number	The SSN, EIN, or carrier assigned number is shown. Services of solo practicing physician/suppliers with more than one identifying number are combined. Group practices should show only services by the group provider ID.
2.	Locality	This is the two digit code used to identify the pricing locality used.
3.	Specialty	The two digit HCFA code of the physician/supplier providing the service.
4.	Subspecialty	The two digit HCFA physician/supplier subspecialty code that a carrier recognizes.
5.	Number of Physician/ Suppliers	The number of physicians or suppliers reporting under this ID number at the end of the calendar year.
6.	Address	The physician/suppliers 5-digit ZIP code.
7.	Type of Provider	Code: -Physicians or sole-proprietorship suppliers for whom SS numbers are shown in the physician ID code field. -Physicians or sole-proprietorship suppliers for whom SS numbers are not available and the carrier's own physician ID code is shown. -Suppliers (other than sole-proprietorships) for whom numbers are used in coding the ID field.

Information		Description
7.	Type of Provider (con.)	-Suppliers (other than sole-proprietorships) for whom numbers are not known and the carrier's own ID code has been shown. -Hospitals and independent laboratories for whom EI numbers are used in coding the ID field. -Hospitals and independent laboratories for whom EI numbers are not available and provider numbers assigned by carrier or HCFA are shown. -Clinics, groups, associations or partnerships for whom EI numbers are used in coding the ID field. -Group practice prepayment plans for whom EI numbers are used in coding the ID field. -GPPP's for whom EI numbers are not available and the carrier's own physician/supplier code has been assigned.
8.	Beneficiary Claim Number	The HICAN as recorded on the claims history.
9.	Procedure Code/MOD	The 5-digit HCPCS procedure code and modifier if any.
10.	Submitted Charge	Dollars and cents.
11.	Allowed Charge	Dollars and cents.
12.	Reimbursement	Dollars and cents.
13.	Reimbursement Indicator	Indicates whether the amount shown in Reimbursement field represents service or claim.

Information		Description
14.	Type of Service	Coded same as Type of Service field of Procedure File.
15.	Place of Service	Coded same as Place of Service field of Procedure File.
16.	Date Paid	Julian date shown on benefit check or the EOMB.
17.	Dates of Service	Julian dates of first and last expense dates of service.
18.	MTUS	Miles/Time/Units/ or number of services.
19.	MTUS Indicator	Coded same as MTUS Indicator field of Procedure File.
20.	Assignment Indicator	Coded as follows: -Participating Provider -All covered and allowed expenses applied to deductible - participating provider -Assignment accepted - nonparticipating provider -Assignment not accepted - nonparticipating provider -Assignment accepted but all covered and allowed expenses applied to deductible - nonparticipating provider -Assignment not accepted and all covered and allowed expenses applied to deductible - nonparticipating provider
21.	Processing Indicator	Coded as follows: -Allowed -Both allowed and denied where a from-to service contains services that were denied -Denied -Reprocessed - adjustments based upon subsequent reprocessing of the claim -Other -Secondary Payor

Exhibit C

Information		Description
22.	Payment Indicator	Coded to indicate which payment screen was used to determine the payment. -Actual Charge -Customary Charge -Prevailing Charge (adjusted, unadjusted, gap fill, etc.) -Other (including ASC facility fees, radiology and outpatient limits, nonpayment because of denial) -Lab Fee Schedule
23.	ESRD Indicator	Coded to identify beneficiary. -ESRD Beneficiary -Not ESRD Beneficiary
24.	Carrier Control Number	Control number assigned to each claim.

Beneficiary File

This file contains a five percent sample of all beneficiaries in the carrier's history file. Sample is based on terminal digits of the HI claim number. All services rendered to the selected beneficiaries are included in this file. Line item detail is also received for all ESRD beneficiaries.

	Information	Description
1.	Beneficiary Claim Number	The HICAN as recorded on the claims history.
2.	Provider ID Number	The SSN, EIN or carrier assigned number as shown. All services of solo-practicing physicians/suppliers, who have been assigned more than one identifying number, are combined. For group practice providers, only those services performed by that group provider ID are shown.
3.	Type of Provider	Same as for Type of Provider field of Provider File.
4.	Specialty Code	The 2-digit HCFA code of the physician/supplier providing the service
5.	Beneficiary Sex Code	Coded as follows: -Male -Female -Unknown
6.	Procedure Code/MOD	The 5-digit HCPCS procedure code and modifier if any.
7.	Submitted Charge	Dollars and cents.
8.	Allowed Charge	Dollars and cents.
9.	Reimbursement Amount	Dollars and Cents.
10.	Reimbursement Indicator	Indicates whether the amount shown in Reimbursement Amount field represents service or claim.
11.	Type of Service	Coded same as Type of Service field of Procedure File.

Exhibit D

Information		Description
12.	Place of Service	Coded same as Place of Service field of Procedure File.
13.	Date Paid	Julian date shown on benefit check or the EOMB.
14.	Dates of Service	Julian dates of first and last expense dates of service.
15.	MTUS	Miles/Time/Units/ or number of services.
16.	MTUS Indicator	Coded same as MTUS Indicator field of the Procedure File.
17.	Assignment Indicator	Coded as follows: -Participating Provider -All covered and allowed expenses applied to deductible - participating provider -Assignment accepted - nonparticipating provider -Assignment not accepted- nonparticipating provider -Assignment not accepted but all covered and allowed expenses applied to deductible - nonparticipating provider -Assignment not accepted and all covered and allowed expenses applied to deductible - nonparticipating provider
18.	Processing Indicator	Coded as follows: -Allowed -Both allowed and denied where a from-to service contains services that were denied -Denied -Reprocessed - adjustments based upon subsequent reprocessing of the claim -Other -Secondary Payor

Information	Description
19. Payment Indicator	Coded to indicate which payment screen was used to determine the payment. -Actual Charge -Customary Charge -Prevailing Charge (adjusted, unadjusted, gap fill, etc.) -Other (including ASC facility fees, radiology and outpatient limits and non-payment because of denial) -Lab Fee Schedule
20. ESRD Indicator	Coded to identify beneficiary. -ESRD Beneficiary -Not ESRD Beneficiary
21. Carrier Control Number	Control number assigned to each claim.
22. Locality	This 2-digit code is used to identify the pricing locality.

VIII. Special Purpose Files

Introduction

This chapter describes several special purpose files which are created for specific projects. These files are created from the detailed billing records and are used to prepare annual publication tabulations and research notes.

Health Insurance Bill Skeleton File for State and County Reimbursement Publication (Exhibit A)

This file is used to create an annual publication: Reimbursement by State and County. This is an annual Medicare publication with reimbursement amounts based on the year claims are approved for payment by intermediaries or carriers. Inpatient hospital pass-thru amounts are not included in their reimbursements. The file is also used in the adjusted annual per capita cost (AAPCC) calculations used to estimate costs to risk HMO's.

The file is created by writing off selected information from each detailed billing and payment record processed by HCFA. The write-off occurs weekly.

Approximately 193,000,000 records are involved annually.

Person Summary File (Exhibit B)

The Person Summary file used to create the annual Medicare Utilization Publication is based on persons receiving reimbursed services in a given calendar year. The file is created from all bills with a date of service in the file year and with amounts reimbursed greater than zero. Data for aged persons are based on a five percent sample of beneficiaries, and for disabled persons are based on a 25 percent sample. These two files are summarized separately, each month, by person, to bring together all reimbursed services for each person during the year.

Approximately 10,000,000 records are involved annually.

Provider Summary File (Exhibit C)

This file contains summarized data on Medicare bill activity for each institutional provider. These utilization bills are summarized monthly by provider number, year and month of through date, and bill type, i.e., Forms HCFA-1450, 1453, 1486, and Discharge Notices (Non-Covered Bills). Data summarized include number of discharges and days of care by type of beneficiary (aged or disabled) and by vital status (alive or dead). In addition, length of stay intervals are aggregated for each summary record.

Approximately 215,000 records are created annually.

Outpatient Bill Skeleton File (Exhibit D)

This file is prepared annually for a 5 percent sample of bills for outpatient hospital services. For each service year, the file is prepared from all bills processed by HCFA through the period ending 12 months after the end of the service year. For example, the 1984 file is prepared from all outpatient bills processed through December 1985 having a date of service in 1984.

Approximately 1,050,000 records are involved annually.

Home Health Agency Skeleton File (Exhibit E)

This file is prepared annually for a 40 percent sample of bills for Home Health Agency services. For each service year, the file is prepared from all bills processed by HCFA through the period ending 12 months after the end of the service year. For example, the 1984 file is prepared from all HHA bills processed through December 1985 having a date of service in 1984.

Approximately 1,200,000 records are involved annually.

Health Insurance Bill Skeleton File
For State And County Reimbursement Publication

	Information	Description
1.	Record Identification Code	-Part B Payment Record -Part A Bill -Part B Bill other than Payment Record
2.	HI Claim Number	Beneficiary's Health Insurance claim number.
3.	State Code of Residence	SSA geographic code
4.	County Code of Residence	SSA geographic code
5.	Date of Birth	Year and Julian date of beneficiary's birth.
6.	Sex	Sex code from HI Master Record: -Male -Female -Unknown
7.	Race	Race code from HI Master Record: -White -Black -Other -Unknown
8.	Format-Payment Record/Form Other than Payment Record	Source of Information: For Payment Records -New Format -Old Format For other than Payment Records: -Inpatient -Outpatient -Christian Science -Home Health -Nonpayment Bills (1450, 1453, 1486, 1487)
9.	Entry Code-Payment Record/Query Code Other than Payment Record	A code for type payment record being submitted: -Original debit -Supplemental -Full credit

Exhibit A

	Information	Description
9.	Entry Code/Query Code (con.)	-Partial credit -Replacement debit -Partial debit -Correction record acknowledges full overpayment; also acknowledges an A reject previously submitted. -Correction record acknowledges partial overpayment. Code indicating status of bill other than payment records: -Interim Bill -Visits Exhausted (HHA) -Final Bill -Discharge Notice (Non-covered Bill) -Debit Adjustment -Credit Adjustment
10.	Recode Code (Payment Record)/Transaction Code (Other than Payment Record)	Code indicating that a payment record is an initial submittal, a resubmittal, an initial reject, or a resubmitted reject: -Initially submitted, accepted records -Resubmitted accepted records -Initially submitted, rejected records -Resubmitted rejected records Codes for records other than payment record indicating type of facility: -Christian Science SNF -Psychiatric Hospital Facility -Tuberculosis Hospital Facility -General Care Hospital Facility -Regular SNF -HHA -Outpatient

	Information	Description
11.	Date Paid (Payment Record)/Date Approved (Other than Payment Record)	Year and Julian date.
12.	Reimbursement Amount	
13.	Medicare Status Code	Code to show reason for beneficiary's entitlement to Medicare benefits: -Aged without ESRD -Aged with ESRD -Disabled without ESRD -Disabled with ESRD -ESRD only
14.	Current Reason for HI Entitlement	-OASI -DIB -Renal
15.	Original Reason for HI Entitle nent	-OASI -DIB -Renal -DIB and Renal
16.	ESRD-DIB Data Indicator	-All Off -ESRD Spouse or Child of Worker -Prior Unqualifying DIB -Both Conditions Present
17.	ZIP Code of Residence	Actual
18.	Date of Service	Year and Julian date date service incurred.
19.	Place of Service	(Payment Records only - blank filled for Bills) -Office -Home -Inpatient Hospital -SNF/Nursing Home -Outpatient Hospital -Independent Laboratory -Other -Independent Kidney Disease Treatment Center

Exhibit A

	Information	Description
20.	Type of Service	(Payment Records only - blank filled for Bills) -Medical Care -Surgery -Consultation -Diagnostic X-Ray -Diagnostic Laboratory -Radiation Therapy -Anesthesia -Assistance at Surgery -Other Medical Service -Charges for whole blood or packed red blood cells -Purchase or rental of used DME -Surgical second opinion -Surgical third opinion Blank for per diem records -Alternate payment method for maintenance dialysis -Live kidney donor
21.	Carrier Number (Payment Records) Provider Number (Other than Payment Records)	For Payment Records, Carrier Number. For bills other than Payment Records, Provider Number shown on Bill.
22.	Total Charges	Total Charges. For Payment Records, this field is the sum of Medical Charges plus Psychiatric Charges.
23.	Total HHA Visit Charges	HHA bills only. Zero filled for other Bill types and Payment Records. Total charges for HHA visits.
24.	Total Inpatient Days of care/Total HHA Visits	Inpatient, SNF, HHA, and Non-Covered Inpatient Bills only. Zero filled for Outpatient and Non-covered HHA Bills and Payment Records. Inpatient Hospital Days of Care/Home Health Agency Visits.

	Information	Description
25.	Inpatient Covered Days	Inpatient, SNF, and Non-Covered Inpatient Bills only. Zero filled for other Bill types and for Payment Records. Number of covered days.
26.	HHA Plan Code	HHA Bills only. Blank filled for other Bill types and Payment Records, except for Non-covered HHA Bills which are force coded 'P'. Type of Bill -Part A -Part B
27.	Service From Date	Bills only. Zero filled for Payment Records. Year and Julian beginning date of stay or service.
28.	Patient Status	Inpatient, SNF, HHA, and Non-covered Bills only. Blank filled for Outpatient Bills and Payment Records. -Discharged -Died -Still Patient -Visits Exhausted
29.	Specialty Code	Payment Records only. Blank filled for Bills. Physician or Supplier Specialty Code.
30.	Date of Admission	Year and Julian date of admission. Inpatient and SNF Bills only. Zero filled for other bill types and Payment Records.
31.	Length-of-Stay	Number of days from date of admission through date of service. Not computed for Interim Bills. Inpatient and SNF Bills only. Zero filled for other bill types and Payment Records.

Exhibit B

Person Summary File

	Information	Description
1.	HI Claim Number	Beneficiary's Health Insurance claim number.
2.	State Code	SSA geographic code obtained from Master Record indicating State of beneficiary's residence.
3.	County code	SSA code obtained from Master Record indicating county of beneficiary's residence.
4.	Medicare Status Code	-Aged without ESRD -Aged with ESRD -Disabled without ESRD -Disabled with ESRD -ESRD only
5.	Renal Insurance Status Indicator	-Worker -Other
6.	Beneficiary Status	-OASDI -RRB -Dual
7.	Date of Birth	Beneficiary's date of birth.
8.	Date of Death	Beneficiary's date of death.
9.	Race	-White -Black -Unknown
10.	Sex	-Male -Female
11.	Age	Age at last birthday as of 07/01/YY if alive at end of year. For aged age 64, consider as age 65. For disabled age 65, consider as age 64. For persons who died, use age on first day of month of death.

Information	Description
12. Patient Status	-Discharged (alive) -Died -Still patient

Reimbursement Amounts (Dollars and Cents)

13. Inpatient Hospital
14. Skilled Nursing Facility
15. HHA Part A
16. Physician and Other Medical Services
17. Outpatient
18. HHA Part B
19. Total Part A
20. Total Part B
21. Total Part A and/or Part B
22. Part A and Part B
23. Part A only
24. Part B only

Exhibit C

Provider Summary Record File

	Information	Description
1.	Provider Number	Six position number identifies a provider. First two positions are the State code. Positions 3 and 4 identify a specific facility. Positions 5 and 6 are numeric except for emergency and Federal hospitals which are coded E and F respectively in the 6th position.
2.	Type of Facility	-Hospital -Skilled Nursing Facility -Christian Science Sanatorium -Home Health Agency -Other
3.	Bill Through Date	Ending date or discharge date shown on bill (YR-MO).
4.	Discharge Data	Data below apply only to discharges from Forms HCFA-1450, HCFA-1453, HCFA 1486, and Discharge Notices (Non-Covered Bills).
	a. Aged	Data for beneficiaries who are aged: -Number of Discharges - alive -Number of Days of care - alive -Number of Discharges - dead -Number of Days of care - dead
	b. Disabled	Data for beneficiaries who are disabled: -Number of Discharges - alive -Number of Days of care - alive -Number of Discharges - dead -Number of Days of care - dead

	Information	Description
5.	Length of Stay Intervals	Number of discharges by interval and type of facility. Counts below apply only to discharges from Forms HCFA-1450, HCFA-1453,HCFA-1486, and Discharge Notices (Non-Covered Bills).
a.	LOS Interval (1)	0-1 day discharges if short-stay 0-15 day discharges if long-stay 0-25 day discharges if SNF
b.	LOS Interval (2)	2-3 day discharges if short-stay 16-30 day discharges if long-stay 26-50 day discharges if SNF
c.	LOS Interval (3)	4-7 day discharges if short-stay 31-60 day discharges if long-stay 51-75 day discharges if SNF
d.	LOS Interval (4)	8-10 day discharges if short-stay 61-90 day discharges if long-stay 76-100 day discharges if SNF
e.	LOS Interval (5)	11-14 day discharges if short-stay 91-120 day discharges if long-stay 101-150 day discharges if SNF
f.	LOS Interval (6)	15-21 day discharges if short-stay 121-150 day discharges if long-stay 151-300 day discharges if SNF
g.	LOS Interval (7)	22-40 day discharges if short-stay 151-180 day discharges if long-stay 301-365 day discharges if SNF

Exhibit D

Outpatient Bill Skeleton Record - 5% Sample

	Information	Description
1.	HI Claim Number	Beneficiary's Health Insurance claim number.
2.	Date of Birth	Year and Julian date of beneficiary's birth.
3.	Sex	Sex code from HI Master Record: -Male -Female -Unknown
4.	Race	Race code from HI Master Record: -White -Black -Other -Unknown
5.	State Code	SSA geographic code obtained from Master Record indicating State of beneficiary's residence.
6.	County Code	SSA geographic code obtained from Master Record indicating county of residence.
7.	ZIP Code of Residence	Actual
8.	Medicare Status Code	-Aged without ESRD -Aged with ESRD -Disabled without ESRD -Disabled with ESRD -ESRD only
9.	Provider Number	Identification number of the provider submitting the claim.
10.	Type of Service	-Inpatient -Outpatient -Other
11.	Diagnosis Code (Field is repeated five times)	Diagnostic code assigned from ICD-9-CM, Volumes I and II.

	Information	Description
12.	Surgical Procedure Code (Field is repeated three times)	Code assigned from ICD-9-CM, Volume III.
13.	Number of Clinic Visits	Actual Number.
14.	Number of Emergency Room Visits	Actual Number.
15.	Covered Charges	Covered charges for each service: -Clinic Visits -Emergency Room -Laboratory -Radiology -Pharmacy -Blood -Ambulance -Physical Therapy -ESRD -Other
16.	Total Covered Charges	Total covered charges for above services.
17.	Date of Last Service	Year and Julian date of last service.
18.	Amount Reimbursed	An interim payment made to the institution. Final reimbursement is made on a cost basis based on the cost report each institution is required to prepare at the end of their fiscal year.
19.	Surgery Indicator	Indicates if surgery was performed.
20.	Unibill Indicator	Indicates if Unibill or Patbill.
21.	Number of Revenue Center Codes	Number of Unibill Revenue Center Codes for services.
22.	Revenue Center Information	
	a. Codes	Identifies specific revenue center.
	b. Units	Number of times the revenue center was accessed.
	c. Charges	Charges for each revenue center code.

Exhibit E

Home Health Agency Skeleton Record - 40% Sample

	Information	Description
1.	HI Claim Number	Beneficiary's Health Insurance claim number.
2.	Date of Birth	Year and Julian date of beneficiary's birth.
3.	Sex	Sex code from HI Master Record: -Male -Female -Unknown
4.	Race	Race code from HI Master Record: -White -Black -Unknown
5.	State Code	SSA Geographic code obtained from HI Master Record indicating State of beneficiary's residence.
6.	County Code	SSA Geographic code obtained from HI Master Record indicating county of beneficiary's residence.
7.	ZIP Code of Residence	Actual
8.	Medicare Status Code	-Aged without ESRD -Aged with ESRD -Disabled without ESRD -Disabled with ESRD -ESRD only
9.	Provider Number	Identification number of the provider submitting the claim.
10.	Record Identification Code	-Part A -Part B
11.	Diagnostic Code	Code assigned from ICD-9-CM, Volumes I and II.
12.	Number of Diagnoses	Number of diagnoses reported on the bill.

	Information	Description
13.	Period From Date	Year and Julian from date of billing period.
14.	Period Through Date	Year and Julian through date of billing period.
15.	Status Code	-Discharged alive -Died -Still Receiving Services
16.	Visits and Charges A. Skilled Nursing Care B. Physical Therapy C. Speech Therapy D. Occupational Therapy E. Medical Social Services F. Home Health Aide G. Other Visits (1) Other Visits (2)	For each category: -Number of Visits -Dollars and Cents
17.	Total Visits	Total visits for all services.
18.	Total Visit Charges	Total charges for HHA visits.
19.	Other Charges	Total other charges.
20.	Total Charges	Total charges including other charges.
21.	Reimbursement Amount	An interim payment made to the institution. Final reimbursement is made on a cost basis based on the cost report each institution is required to prepare at the end of their fiscal year.
22.	Query Code	Code indicating status of the bill.
23.	Unibill Indicator	Indicates whether Unibill or Patbill.
24.	Original BIC	Beneficiary Identification code as submitted on bill.

IX. Medicare History Sample File

Introduction

The Health Insurance System provides for processing and maintenance of all utilization health insurance bills, payment records, and enrollment records. As a by-product of this system, individual HCFA statistical files are obtained to provide data bases for all types of information on the health insurance program. Until the implementation of the Medicare History Sample, all requests for person data over a time period of more than a single year had to be processed by combining various individual files. A more efficient method of obtaining hospital and medical insurance data is to create a sample file consisting of selected fields from the various Medicare bill files on an ongoing scheduled basis. Such a file permits more in-depth studies of utilization patterns over extended time periods.

The Medicare History Sample file is intended to provide more efficient access to person data on a longitudinal basis. This file, being a combined file and having annual updates, has eliminated the problem of having to refer to old files with old formats. Information for all years (representing services after 1973) are consistent and fully documented and contained in this one file.

Preparation of Medicare History Sample (MHS) File

The MHS file is prepared on a 5 percent sample person basis for years 1974 and later and provides a combined record of all Medicare activity for each year. Selection of beneficiaries to be included in this file is based on the ever-enrolled (1974 and later) concept. Thus, beneficiaries enrolled in the Medicare program after 1973, regardless of utilization activity, are represented in this file. Selected personal characteristics are obtained from both the active and inactive HISKEW files. Utilization data for each year are selected from inpatient hospital, SNF, home health agency, and outpatient bills that are processed by Medicare intermediaries, and physician service information is obtained from payment records that are processed by Medicare carriers.

Each portion obtained is then combined to form one record for each Medicare beneficiary within the sample on an ongoing basis. Once a beneficiary is included in the MHS sample that person remains on the file regardless of activity or death. This provides the flexibility for ready access of person data needed to follow utilization patterns of each sample beneficiary.

The initial selection of beneficiaries included in this sample file was based on records obtained from the active and inactive HI Master Enrollment Record as of the update closest to April 1, 1975, with the following characteristics:

1. Primary and/or cross-reference HI claim number in the 5 percent sample.
2. Current entitlement to hospital insurance benefits (Part A) and/or supplementary medical insurance benefits (Part B) was before January 1, 1975, without current termination before January 1, 1974, i.e., anyone ever enrolled in 1974.

Subsequent updates of additional beneficiaries will continue to be based on entitlement after 1973 and will be obtained annually from the updated Master Enrollment File. In addition to newly entitled beneficiaries, those previously included are reselected from the enrollment file from subsequent years for use in a current update. This provides the MHS file with current demographic characteristics. An annual segment is appended to the Master Record portion of all active beneficiaries and provides the means for noting changes in benefit status, residency, and type of enrollment. The status and coverage

characteristics are based as of July 1 of the reference year.

All sample utilization records (bills and payment records) included in the initial preparation of the MHS were selected from records processed through June 1975 with services in 1974.

Subsequent annual updates to the MHS included those initial debit utilization records with service dates after December 31, 1973, processed since the prior years' file through the June update of the current year. Thus, when accreting for 1980 activity, only sample records with service dates of 1974-1980 and processed through June 1981 are used. The types of utilization records used to obtain information are as follows:

1. Stay Records

   a. Inpatient hospital stay records representing complete stays sequenced by date of discharge.

   b. Inpatient SNF stay records representing complete stays or incomplete stays.

The incomplete SNF stay record is replaced in subsequent updates by a complete stay record when the discharge record for that stay has been processed. Effective with the 1979 update, SNF stays are sequenced by date of admission. Multiple inpatient hospital or SNF stays for the year are also included in the file.

2. Home health agency, outpatient, and payment records are summarized by type of record on a calendar year basis and included in the annual update of the MHS.

Two additional source files are used to annotate the MHS sample records with information relating to third party and GPPP activity. These data are obtained from the State Buy-In and GPPP member files annually, and identify those MHS beneficiaries ever enrolled in the reference year as a State Buy-In and/or a member of a GPPP.

Contents of the MHS Record

The complete MHS record varies in size based on whether Medicare utilization is present or not, type of service utilized by the beneficiary, and the number of years involved. The file is maintained in chronological sequence by type of record and by date(s) of service. Exhibit A details each possible type of service present for a MHS beneficiary.

Volume Statement

Approximately 1,600,000 individual HISKEW accounts are represented on the Medicare History File. In addition, the individual sections contain the following number of records:

1. Annual Demographic Section - A demographic record is added each year the enrollee is alive. Approximately 1,300,000 records were initially established in 1974. Subsequent years have added approximately 1,400,000 records annually.

2. HHA, Outpatient and Payment Records - An annual record is added for each type of service used during the year. The approximate number of records added each year are shown below:

a. HHA -35,000
b. Outpatient -350,000
c. Payment Records -700,000

3. Inpatient and SNF Records - All stay records are added to the account as they become available. The approximate number of records added each year are shown below:

a. I/P - 450,000
b. SNF - 20,000

Exhibit A

Medicare History Sample Record Contents

Fixed Demographic Section

	Information	Description
1.	Type of Record	Blank
2.	HI Claim Number	Beneficiary's Health Insurance claim number.
	a. Account Number b. Equatable BIC Code	
3.	Cross-Reference Claim Number 1/	
	a. X-R Account No. b. X-R BIC Code	Blank if no cross-reference number.
4.	Status of HIC Number 1/	-Current number in 5 percent sample - no cross-reference. -Both current and cross-reference numbers in 5 percent sample. -Current number in 5 percent sample. Cross-reference not in sample. -Cross-reference in 5 percent sample. Current number not in sample. Note: For records with the current HI claim number not in the sample, the cross-reference number is placed in the current HI claim number field while the cross-reference claim number field contains the actual current number.
5.	Dual Entitlement 1/	-No -Yes
6.	Date of Birth	Julian date of beneficiary's birth.
7.	Sex Code	-Male -Female -Unknown
8.	Race	-White -Black -Other -Unknown

Information	Description
9. Part 'A' Dates 1/ a. Latest entitlement b. Latest termination c. Prior entitlement d. Prior termination	Julian date.
10. Reason for Latest Part 'A' termination	-No termination -Death -Non-payment of premium -Voluntary withdrawal -Entitled under another number -DIB recovery
11. Part 'B' Dates 1/ a. Latest entitlement b. Latest termination c. Prior entitlement d. Prior termination	Julian date.
12. Reason for Latest Part 'B' Termination 1/	-No termination -Death -Non-payment of premium -Voluntary withdrawal -Entitled under another number -DIB recovery
13. Date of Death 1/	Julian date of beneficiary's death.
14. Original Reason for Entitlement	-OASI -DIB -RENAL -DIB and RENAL
15. End Stage Renal Disease Indicator	Coded to indicate method of original notice of ESRD. -MBR Notice of ESRD -HI Notice of ESRD -NIH Notice of ESRD -MBR and HI Notice of ESRD -MBR and NIH Notice of ESRD -HI and NIH Notice of ESRD -MBR, HI, and NIH Notice of ESRD

Exhibit A

Annual Demographic Section 2/

	Information	Description
1.	Type of Record	Constant '*'
2.	Reference Year	YY
3.	Current Reason for Entitlement	-OASI -DIB -Renal -Both DIB and Renal
4.	Medicare Coverage 3/	-No coverage or Dead (include beneficiaries whose start date is after reference year) -Part A entitlement only -Part B entitlement only -Both Part A and Part B
5.	Medicare Status Code 3/	-Aged without ESRD -Aged with ESRD -Disabled without ESRD -Disabled with ESRD -ESRD only
6.	Insured Status 4/	-Uninsured -Insured
7.	State and County Code of Residence	SSA Geographic Code.
8.	ZIP Code of Residence	Actual
9.	GPPP Plan Number	Blank if no GPPP plan. Obtained from GPPP Master file.
10.	State Welfare Buy-In	-State Welfare Buy-In -No State Welfare Buy-In. Obtained from Third Party Master File.

HHA Section 5/

	Information	Description
1.	Type of Record	Constant 'A'
2.	Reference Year	YY. Obtained from "Ending Date of Service" fields.
3.	Part 'A' Totals 6/	Based on plan code "P" Part A services. Totals accumulated for the year.
	a. Visits b. Charges c. Other Service Charges d. Reimbursement Amount	
4.	Part 'B' Totals 6/	Based on plan code "M" Part B services. Totals accumulated for the year.
	a. Visits b. Charges c. Other Service Charges d. Reimbursement Amount	
5.	Patient Status Indicator (Based on the record having the latest status date in the reference year)	-Discharged alive -Died -Still receiving benefits -Visits exhausted
6.	Patient Status Date (Based on the record having the latest status date in the reference year)	Julian date.

Exhibit A

Outpatient Section 5/

	Information	Description
1.	Type of Record	Constant 'B'
2.	Reference Year	YY. Obtained from "Date of Last Service" field.
3.	Outpatient Services	Based on third position of provider number equaling 0, 2, 3, or 4 and type of service code is 2 (O/P Type). Totals accumulated for the year.
	a. Number of Bills	
	b. Covered Charges	
	c. Reimbursement Amount	
4.	Inpatient Services	Based on third position of provider number equaling 0, 2, 3, or 4 and type of service code is 1 (I/P Type). Totals accumulated for the year.
	a. Number of Bills	
	b. Covered Charges	
	c. Reimbursement Amount	
5.	Other Services	Based on all other combinations of third position of provider number and type of service code. Totals accumulated for the year.
	a. Number of Bills	
	b. Covered Charges	
	c. Reimbursement Amount	

Inpatient Hospital Stay Section 5/

	Information	Description
1.	Type of Record	Constant 'D'
2.	Reference Year	YY - Year from "Discharge Date" field.
3.	Date of Admission	Julian date of admission in this stay.
4.	Provider Data	
	a. Number	Identification number of the provider submitting the claim.
	b. Type	-Short-stay -Long-stay -TB -Psychiatric -Christian Science -Emergency -Federal -Other
5.	Date Benefits Exhausted	Julian date.
6.	Number of Covered Days	Includes lifetime reserve days.
7.	Discharge Data	
	a. Status	-Alive - no surgical indicator -Dead - no surgical indicator -Benefits Exhausted - no surgical indicator -Alive - surgical indicator -Dead - surgical indicator -Benefits Exhausted - surgical indicator
	b. Date	Julian date of discharge.
	c. Principal Diagnosis Code	-ICD-9-CM, Volumes I and II, for 1979 and later -ICDA-8 for 1978
	d. Additional Diagnosis Indicator	-No additional diagnosis -Additional diagnosis -Unknown additional diagnosis
	e. Source of Coding	-ICDA-8 -ICD-9-CM

8.	Surgical Data	
	a. Date	Julian date of surgery.
	b. Principal Surgery Code	-ICD-9-CM, Volume III, for 1979 and later -CPT for 1978
	c. Additional Procedure	-No surgery involved -No additional procedure -Additional procedure -Unknown additional surgical procedure
9.	Totals a. Charges b. Non-Covered Charges c. Deductions d. Reimbursement Amount	Dollars Only.
10.	Lifetime Reserve Days	Number of lifetime reserve days used in this stay.
11.	Coinsurance Days	Number of coinsurance days used in this stay.

SNF Stay Section 5/

	Information	Description
1.	Type of Record	Constant 'E'
2.	Reference Year	YY - Year from "Admission Date" field.
3.	Admission Date	Julian date the beneficiary entered the care of the provider.
4.	Medicare Provider Number	Identification number of the provider submitting the claim.
5.	Admission Data	
	a. Diagnosis	-ICD-9-CM, Volumes I and II, for 1979 and later -ICDA-8 for 1978
	b. Additional Diagnosis	-No additional diagnosis -Additional diagnosis -Unknown additional diagnosis
	c. Source of Coding	-ICDA-8 -ICD-9-CM
6.	Date Benefit Exhausted 8/	Julian date.
7.	Number of Covered Days	
8.	Discharge Data	
	a. Status 8/	-Alive -Dead -Still patient (used only for benefits exhausted stay where discharge notice not yet received)
	b. Date	Julian date of discharge or death.
9.	Qualifying Stay Dates	Julian dates of stay in hospital that qualify claimant for SNF.
	a. From Date b. To Date	

10.	**Totals** a. Charges b. Covered Charges c. Coinsurance Amount d. Reimbursement Amount	Dollars Only.
11.	Total Estimated Charge Indicator	-No -Yes
12.	Coinsurance Days	Total number of coinsurance days used in the stay.

Payment Record Section 5/

	Information	Description
1.	Type of Record	Constant 'C'
2.	Reference Year	YY. Obtained from "Last Expense Date" field.
3.	Non-Hospital Based Services	Based on totals accumulated from records with payment codes indicating payments made for services shown on HCFA-1490 and HCFA-1556. Totals accumulated for the year.
	a. Number of Records b. Reasonable Charges 7/ c. Reimbursement Amount	
4.	Physician Services	Based on totals accumulated from records with payment codes indicating payments made for services shown on HCFA-1490 and HCFA-1556 and with specialty codes 01-40, 48, 49, 70, or 99. Totals accumulated for the year.
	a. Number of Records b. Reasonable Charges 7/ c. Reimbursement Amount	
5.	Surgical Services	Based on totals accumulated from records with payment codes indicating payments made for services shown on HCFA-1490 and HCFA-1556 and with specialty codes 01-40, 48, 49, 70, or 99 and with type of service code 2. Totals accumulated for the year.
	a. Number of Records b. Reasonable Charges 7/ c. Reimbursement Amount	
6.	Supplier Services	Based on totals accumulated from records with payment codes O/T 4 or 5 and with specialty codes 51-69, 87, or 88. Totals accumulated for the year.
	a. Number of Records b. Reasonable Charges 7/ c. Reimbursement Amount	

Exhibit A

	Information	Description
7.	Hospital Services	Based on totals accumulated from records with payment codes indicating payments made for services shown on HCFA-1554. Totals accumulated for the year.
	a. Number of Records	
	b. Reasonable Charges 7/	
	c. Reimbursement Amount	
8.	Psychiatric Charges	Accumulated total for the year.
9.	Unassigned Totals	Based on totals accumulated from records with payment code indicating payment made to beneficiary. Totals to beneficiary. Totals accumulated for the year.
	a. Number of Records	
	b. Reimbursement Amount	

FOOTNOTES

1/ If necessary, recoded during each annual update.

2/ The annual portion will be present for each year account is active. Data are obtained during each annual update and represent status as of the input cut-off date.

3/ As of July 1 of reference year.

4/ Any beneficiary with the first position of the original BIC code J, K, M, or T is considered as uninsured.

5/ All money fields are rounded to the nearest dollar.

6/ Parenthetical characters refer to corresponding letters of Form HCFA-1487, HHA Billing Report.

7/ Reasonable charges are the sums of psychiatric charges plus medical charges.

8/ All benefits exhausted stays (no discharge record) are replaced when the complete stay becomes available. Substitution for a complete stay is made based on match of HI claim number, date of admission, and provider number.

X. End Stage Renal Disease Program Management and Medical Information System

Introduction

Persons with End Stage Renal Disease (ESRD) became eligible for Medicare benefits on July 1, 1973. The ESRD Program Management and Medical Information System (PMMIS) captures patient-specific data on Medicare ESRD beneficiaries. The system also captures certification and other types of information on providers approved by Medicare to furnish kidney dialysis and transplant services, and contains aggregate patient population counts.

Source Documents and Input

Documents containing patient-specific information are originated at the social security office and renal provider levels. In addition, inpatient and outpatient billing records are passed through the PMMIS and certain data are extracted and made a part of the record. Aggregate patient population data are received annually from renal providers; and provider certification, Minimum Utilization Rates (MUR), and other provider characteristics come from the regional offices and/or intermediaries.

The patient-specific forms are batched in Baltimore and sent to Salinas, CA, for keying. They are transmitted back for introduction into the Health Insurance System, which routes them along with all bills for ESRD patients to the PMMIS.

Aggregate patient population data are received in hard copy form from the renal providers; these data are keyed in Salinas and made part of the Facility Survey File. Certification and other provider characteristics data are accreted on-line into the Renal Provider File, which interfaces with the Medicare Provider Master File.

Update Mechanism and Quality Control Measures

The patient-specific information is updated monthly. Master identification records are updated from identification records from the Health Insurance System. Patient-specific records from the keyed forms are edited and posted if valid. Records with errors are routed to an on-line file for correction. Inpatient and outpatient billing information is posted to the appropriate beneficiary records. At the conclusion of this batch updating, an M204 on-line data base is created containing much of the patient-specific data from the batch files.

Provider certification and characteristics data are updated as received; aggregate patient population data are updated annually on magnetic tapes.

Hard copy data are reviewed and verified prior to keying. Data, once keyed, are run through consistency and logic edits. Rejected records appear on error listings and are corrected manually and rerun through the system.

Dependent Systems and Outputs

No other systems are dependent on the PMMIS.

Recurring tabulations, analyses, and reports are prepared on monthly and annual bases.

Special reports are prepared and analyses performed to respond to requests from other components of HCFA and DHHS, the Congress, the renal professional community, the media, and various research organizations.

Exhibit A describes the patient-specific portion of the PMMIS.

Exhibit B describes the magnetic tape containing provider characteristics and aggregate patient population data.

ESRD PMMIS Transplant--Pre-1983 Format

Information	Description
ESRD PMMIS TRANSPLANT INCIDENT	Source: HCFA-600-1 Transplant record, HCFA-1453 Inpatient record. Restricted use data file.
1. Record Identification Code	Identifies the record format being processed.
2. Social Security Number and Beneficiary Identification Code	PMMIS Internal format. Converted from HIM format. Full code is retained as beneficiary identification code.
3. Transplant Record Post Date	Date transplant posted.
4. Record Format Indicator	-Old format: 75 positions -HCFA-2745 format: 370 positions
5. Incident Counter	Ascending chronological sequence number distinguishing recurring records of this type.
6. Transplant Provider	Provider reporting transplant Source: HCFA-600-1, HCFA-1453.
7. Date of Transplant	Date of reported transplant.
Donor Data	Following data pertain to organ donor. Source: HCFA-600-1
8. Transplant Donor Type	-Monozygotic Twin -Dizygotic Twin -Sibling -Genetic Parent -Child -Cadaver -Other -Living related
9. Age at Transplant	
10. Race Code	Source: HCFA-600-1, Item 13. Possible values -White -Black -Oriental -American Indian -Other -Unknown

Exhibit A

Information	Description
11. Blood Type	Donor blood type.
Recipient Data	Following data pertain to organ recipient.
12. Race Code	Source: HCFA-600-1, Item 13. Possible values -White -Black -Oriental -American Indian -Other -Unknown
13. Sex Code	Code which identifies the sex of the beneficiary (from master file). -Unknown -Male -Female
14. Blood Type	Recipient blood type.
15. Cross-Match Results	Source: HCFA-600-1, Item 15. -Unspecified -Not performed -Positive -Negative -Equivocal
16. Lymphocyte Culture	Source: HCFA-600-1, Item 16. -Unspecified -Not performed -Positive -Negative -Equivocal
17. Date of Culture	Julian date. Source: HCFA-600-1, Item 16.
18. Tissue Type Donor	Source: HCFA-600-1, Item 18. Codes indicating tissue type. -A-AW1 Series -A-AW2 Series -B-BW1 Series -B-BW2 Series -CW1 Series -CW2 Series

	Information	Description
19.	Tissue Type Recipient	Source: HCFA-600-1, Item 17. Codes indicating tissue type. -A-AW1 Series -A-AW2 Series -B-BW1 Series -B-BW2 Series -CW1 Series -CW2 Series
20.	Days in Inpatient Hospital	Computed from HCFA-1453 discharge record.
21.	Type of Inpatient Dialysis	-Hemodialysis -Peritoneal -Both
22.	Number of Dialysis Sessions	
23.	Hospital Indicator	For future use.
24.	Recycle Indicator	For internal use.
25.	Cross-Match Indicator	Indicates a cross-match was made. -No -Yes
26.	Transplant Status	-Source: HCFA-1483, HCFA-1453, HCFA-600-1, HCFA-2746 -Transplanted, not on dialysis -Transplanted, on support dialysis -Transplanted, no additional information -Failed transplant -No transplant
27.	Inpatient Indicator	-HCFA-600-1 only, no stay record or AMCS record received. -HCFA-600-1, and stay record posted. -HCFA-600-1, stay record and AMCS record posted -No HCFA-600-1, stay record and AMCS record only

Exhibit A

ESRD PMMIS Identification Record

	Information	Description
1.	Record Identification Code	Identifies the record format being processed.
2.	Social Security Number and Beneficiary Identification Code	PMMIS internal format. Converted from HIM format. Full code is retained as beneficiary identification code.
3.	Cross-Reference Claim Number and Beneficiary Identification Code	Previous health insurance claim number or beneficiary's own social security number. Beneficiary identification code "**" indicates the beneficiary's own social security number. Identifies relationship to SSN.
4.	Type of PMMIS Transaction	Possible values A-H, J, X, Y. Type of most recent transaction to PMMIS. -Chronic Renal Disease Reimbursement Utilization Record (CRD RUS) -HI Master Identification Record -ESRD Transplant Record -ESRD Patient History Record -ESRD Dialysis Record -ESRD Hospital Record -Noncovered Bill Record -ESRD Death Notice Record -Master Record Cross-Reference Maintenance Record -Master Record Disabled Cross-Referencing -1978 Census Record
5.	Date PMMIS Transaction	Julian date of most recent transaction to PMMIS.
6.	HIM Identification Post Date	Date HIM Master Identification record was posted to the PMMIS.
7.	Date of Accretion	Julian date the record or trailer was accreted to the file.
8.	Date of Birth	Julian date of beneficiary's birth.
9.	Date of Death	Julian date of beneficiary's death.

Information	Description
10. Sex Code	Code which identifies the sex of the beneficiary (from Master File). -Unknown -Male -Female
11. Race Code	Code which identifies the race of the beneficiary (from Master File). -Unknown -White -Black -Other
12. Ledger Account File Code	Indicates benefit payment status and the reason for such status.
Current Part A Dates	Dates refer to the most recent period of entitlement to Medicare Part A (HI) benefits. Note: Entitlement to Part A (HI) and not Part B (SMI) is possible.
13. Date of Entitlement	Julian date entitlement began.
14. Date of Termination	Julian date entitlement terminated.
Current Part B Dates	Dates refer to most recent entitlement to Medicare Part B (SMI) benefits.
15. Date of Entitlement	Julian date entitlement began.
16. Date of Termination	Julian date entitlement terminated.
Prior Part A Dates	
17. Date of Entitlement	Julian date entitlement began. Zeroes indicate no entitlement.
18. Date of Termination	Julian date entitlement terminated.
Prior Part B Dates	
19. Date of Entitlement	Julian date entitlement began.
20. Date of Termination	Julian date entitlement terminated.

Exhibit A

	Information	Description
21.	HIM Source Date of Death	-All off -Master Beneficiary Record (MBR) -Medical bill -Beneficiary deceased, Source: MBR/Medical bill or clerical
22.	Early Entitlement Indicator	For internal use only. -No early entitlement -Early entitlement
23.	Original Reason for Entitlement	Indicates the reason for the beneficiary's original entitlement to Medicare benefits. -Old Age and Survivors Insurance (OASI) -Disability Insurance Benefits (DIB) -Renal -DIB and Renal
24.	Current Reason for Entitlement	Indicates the reason for the beneficiary's current entitlement to Medicare benefits. -OASI -DIB -Renal -DIB and Renal
25.	End Stage Renal Disease (ESRD) Indicator	This code indicates the source of the notice of end stage renal disease. -No ESRD -MBR -HI -National Institutes of Health (NIH) -MBR and HI -MBR and NIH -HI and NIH -MBR, HI, and NIH -Clerical -MBR and Clerical -HI and Clerical -NIH and Clerical -MBR, HI, and Clerical -MBR, NIH, and Clerical -HI, NIH, and Clerical -MBR, HI, NIH, and Clerical
	Beneficiary Name	
26.	Beneficiary Surname	May be truncated.

Information	Description
27. Given Name	Given name or first name. May be truncated.
28. Middle Initial	Beneficiary's middle initial.
Beneficiary Address Data	
29. State Code	SSA Standard State Code.
30. County Code	SSA Standard Codes.
31. ZIP Code	May contain spaces or invalid codes.
32. Network of Residence	Determined from State Code and County Code.
33. HCFA Region	Determined from State Code.
Beneficiary Address Prior Year	
34. State Code	SSA Standard State Code.
35. County Code	SSA Standard Codes.
Beneficiary Address 2 Years Prior	
36. State Code	SSA Standard State Code.
37. County Code	SSA Standard Codes.
38. Race Code ESRD PMMIS	Posted from latest HCFA-2728 (10/81) or HCFA-2745 (1/82) received. Possible values -American Indian/Alaskan Native -Asian/Pacific Islander -Black -White -Unknown
39. Age ESRD PMMIS	Current age computed as of July 1 or as of July 1 of year of death.
40. First Date of ESRD Service	Earliest reported date of dialysis or transplant. Source: HCFA-1450, HCFA-1453, HCFA-1483, HCFA-2728, HCFA-600-1, HCFA-2745

Exhibit A

	Information	Description
41.	Type of First ESRD Service	-Dialysis -Transplant
42.	Date Claim Number Cross-Referred	Date HI cross-reference transaction is posted to PMMIS.
43.	Investigation Code	For future use.
44.	Source of Primary Provider Code	-Transplant provider, transplant functioning -Transplant provider, beneficiary died within 90 days of transplant -Dialysis provider, billed CAPD services in latest quarter -Dialysis provider, billed 21 most recent sessions -Dialysis provider, billed most sessions in latest 2 quarters -Transplant provider, HCFA-2728 -Dialysis provider, HCFA-2728
45.	Primary Provider	
46.	Year of Part B Expense	
47.	Queried Part B Expenses	Linked to year of Part B expense.
48.	M204 Database Indicator	For future use.
49.	First Date of Dialysis	Julian date. Earliest legitimate date.
50.	Source First Date of Dialysis	-Earliest HCFA-2728 -Earliest billed dialysis sessions, HCFA-1483, HCFA-2743 -DOEA (CREC = 2, EE1 = 1) -DOEA - 3 months (CREC = 2)
51.	Medicare Status Code	Indicates reason for Medicare entitlement as of a point in time. -Aged without ESRD -Aged with ESRD -Disabled without ESRD -Disabled with ESRD -ESRD only
52.	Current Dialysis Type	Most current (date of service) reported type of dialysis. -Hemodialysis -Peritoneal -Both -CAPD

	Information	Description
53.	Death Notification Provider	Provider submitting ESRD Death Notification, HCFA-2746.
54.	Place of Death	Source: HCFA-2746, HCFA-1453, HCFA-1450 -Hospital -Dialysis Facility -Home -Other -Unreported
55.	Autopsy Indicator	Source: HCFA-2746 -Yes -No -Unreported
56.	Primary Cause of Death	Source: HCFA-2746 -Pericarditis (Including cardiac tamponade) -Myocardial infarction, acute -Cardiac (Other than percarditis or myocardial infarction, acute) -Cerebrovascular (Including spontaneous subdural hematoma) -Embolism, air -Embolism, pulmonary -GI hemorrhage -Vascular access -Hemorrhage -Pulmonary infection -Septicemia -Viral hepatitis -Infection -Hyperkalemia -Pancreatitis -Malignancy -Withdrawal from dialysis -Suicide -Accidental death, treatment related -Accidental death, not treatment related -Unknown cause -Other (specify in remarks)
57.	Secondary Cause of Death	See causes above.
58.	Batch Number HCFA-2746	Internal use (1983 to current).

Exhibit A

	Information	Description
59.	Transplant Status	Source: HCFA-1483, HCFA-1453, HCFA-1450, HCFA-2745, HCFA-2746 -Transplanted, not on dialysis -Transplanted, on support dialysis -Transplanted, no additional information -Failed transplant -No transplant
60.	Death Indicator	-HIM only -HCFA-2746 only -Both -No death indicator
61.	Malignancy Indicator	Malignancy indicated Source: HCFA-2742 (expired 10/81), HCFA-2746
62.	Number of Medical Evidence Records	Number of RIC "B" records on the file.
63.	Number of Transplant Records	Number of RIC "C" records on the file.
64.	Number of Dialysis Records	Number of RIC "G" records on the file.
65.	Number of Inpatient Stay Records	Number of RIC "E" records on the file.
66.	Current Treatment Setting	Most current (date of service) reported treatment setting. -Staff -Self-Care -Self-Care Training -Home -Inpatient -Transplant
	Most Current Data	
67.	Dialysis Provider	Dialysis provider reporting medical evidence. Source: HCFA-2728, Item 13; HCFA-2742, Item 9.
68.	Date of Dialysis	"Through date" of dialysis claim, first date of dialysis from HCFA-2728 if no billed date of dialysis. Source: HCFA-1483, HCFA-2728

Information	Description
69. Transplant Provider	Provider reporting transplant. Source: HCFA-600-1, HCFA-2745, HCFA-1453, HCFA-1450
70. Date of Transplant	Date of reported transplant.
71. Transplant Donor Type	Source: HCFA-600-1, HCFA-1453, HCFA-1450 -Monozygotic Twin -Dizygotic Twin -Sibling -Genetic Parent -Child -Cadaver -Other -Living Related -Unspecified (HCFA-1453)
72. Inpatient Stay Date	Date of admission of reported inpatient stay. Source: HCFA-1453, HCFA-1450
73. Source Date Transplant Failure	Earliest of: -Date of subsequent transplant -Midpoint of first quarter after 22 sessions occurred. -Date of nephrectomy -Date of death (death occurred within 90 days of transplant) -Date of death (death occurred during transplant hospital stay) -Date of death (death notification form indicated transplant failed)
74. Date of Transplant Failure	Julian date.
75. Transplant Death	-Death occurred within 90 days of transplant or within the same hospital stay. -Death occurred more than 90 days after transplant -No date of death
76. Beneficiary Identification Code	Identifies beneficiary's relationship to SSN.

Exhibit A

Information	Description
77. Possible Renal Activity Indicator	Errored records received. -None -HCFA-2728 -HCFA-2745 -HCFA-2728, HCFA-2745 -HCFA-2746 -HCFA-2728, HCFA-2746 -HCFA-2745, HCFA-2746 -HCFA-2728, HCFA-2745, HCFA-2746 -HCFA-1483 -HCFA-1453 -HCFA-1450 -Other
78. Date Most Current Errored Record	Links to Possible Renal Activity Indicator Field.
79. Recycle Indicator	For internal use.
80. Control Count	For internal use.
81. Delete Count	For internal use.
82. Date Last Update From HIM	Date most current HIM identification record posted.
83. Renal Indicator	-Clerically Set -Not set clerically -Data code 38 in HIM set using HCFA-1363.

ESRD Medical Evidence Record

	Information	Description
	ESRD MEDICAL EVIDENCE RECORD	A record can occur for each period of ESRD entitlement. Source: HCFA-2728 (10/81 to present) HCFA-2742 (1/77 to 9/81)
1.	Record Identification Code	Identifies the record format being processed.
2.	Social Security Number and Beneficiary Identification Code	PMMIS internal format. Converted from HIM format. Full code is retained as beneficary identification code.
3.	Medical Evidence Post Date	Date medical evidence record was posted to the PMMIS.
4.	Primary Disease Causing ESRD	Code from International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM).
5.	Dialysis Provider	Dialysis provider reporting medical evidence. Source HCFA-2728, Item 18; HCFA-2742, Item 9.
6.	First Type of Regular Dialysis	-Hemodialysis -Peritoneal -Both -Continuous Ambulatory Peritoneal Dialysis (CAPD)
7.	Date Regular Dialysis Began	
8.	Transplant Provider	Provider reporting transplant.
9.	Date of Transplant	Julian date of reported transplant.
10.	Transplant Status	-Functioning -Rejected
11.	Date Returned to Dialysis	
12.	Self-Care Training Provider	Medicare-approved ESRD training provider.

Exhibit A

	Information	Description
13.	Date Training Began	
14.	Type of Self-Care Training	-Hemodialysis -Peritoneal -CAPD
15.	Date of Medical Certification	
16.	Source of Medical Evidence	-HCFA-2728 -HCFA-2742
17.	Processing Batch Number	For internal use.

ESRD PMMIS Transplant -- Current Format

	Information	Description
1.	Record Identification Code	Identifies the record format being processed.
2.	Social Security Number and Beneficiary Identification Code	PMMIS internal format. Converted from HIM format. Full code is retained as beneficiary identification code.
3.	Transplant Record Post Date	Date transplant record posted to PMMIS.
4.	Record Format Indicator	-Old format: 75 positions -HCFA-2745 format: 370 positions
5.	Incident Counter	Ascending chronological sequence number distinguishing recurring records of this type.
6.	Transplant Provider	Provider reporting transplant. Source: HCFA-2745, HCFA-1453, HCFA-1450
7.	Date of Transplant	Date of reported transplant.
8.	Transplant Donor Type	-Cadaveric -Living Related
9.	Disposition Code	Original reply code.
10.	Batch and Sequence	Assigned by clerical unit receiving record. This number represents- 4-position Date (YDDD) 1-position Type 2-position Sequence Field 2-positions (01 - 99) assigned electronically
11.	Days in Inpatient Hospital	Computed from HCFA-1453 or HCFA-1450 discharge record.

Exhibit A

	Information	Description
12.	Type of Inpatient Dialysis	-Hemodialysis -Peritoneal -Both
13.	Number of Dialysis Sessions	
14.	Transplant Status	Source: HCFA-1483, HCFA-1453, HCFA-2745, HCFA-2746, HCFA-1450 -Transplanted, not on dialysis -Transplanted, on support dialysis -Transplanted, no additional information -Failed transplant -No transplant
15.	Inpatient Indicator	-HCFA-2745 only, no stay record or AMCS record received. -HCFA-2745 and stay record posted. -HCFA-2745, stay record and AMCS record posted. -No HCFA-2745, stay record and AMCS record only.
16.	Number of Pregnancies	
17	Race Code ESRD PMMIS	Posted from latest HCFA-2728 (10/81); HCFA-2745 (1/82) received. Possible values -American Indian/Alaskan Native -Asian/Pacific Islander -Black -White -Unknown
18.	Ethnicity	-Hispanic Origin -Not of Hispanic Origin
19.	Date of Transplant	Date of reported transplant.
20.	Transplant Number	
21.	Date First Previous Failure	
22.	Date Second Previous Failure	
23.	Date Third Previous Failure	

Information	Description
24. Provider Number	Provider identification number.
25. Surgeon's Name	
26. Recipient Blood Group	
Percent Reactive Antibody	
27. High	Expressed as a percentage.
28. At Transplant	Expressed as a percentage.
29. MLC (1-Way)	
30. MLC (2-Way)	
31. MLC (Not Done)	
32. Stim Index (1-Way)	
33. Stim Index (2-Way)	
34. Relative Response (1-Way)	
35. Relative Response (2-Way)	
36. HLA Haplotyped	
Recipient Haplotype Data	
37. Locus A1	
38. Locus A2	
39. Locus B1	
40. Locus B2	
41. Locus C1	
42. Locus C2	
43. Locus DR1	
44. Locus DR2	
45. Locus MB1	
46. Locus MB2	

Exhibit A

	Information	Description
47.	Nephrectomy	-One -Two -No
48.	Date of Nephrectomy	
49.	Reason for Nephrectomy	Free fielded - Can contain up to 5 entries. -Uncontrolled hypertension -Infection -Reflux -Routine preparation for transplant -Other
50.	Splenectomy	-Yes -No
51.	Date of Splenectomy	
	HBs AG Status	
52.	Positive Ever	
53.	Positive Now	
54.	Antibody to HBs AG	
55.	CMV Status: Antibody Present	-Yes -No -Unknown
	Blood Transfusion Data	
56.	Pre-Transplant	-Yes -No
57.	Number of Transfusions	
58.	Frozen Blood Used	
59.	Date of Last Transfusion	
60.	At Time of Transplant	-Yes -No
61.	Creatinine Decline	-Yes -No -Unknown

	Information	Description
62.	Donor Type	-Cadaveric -Living related
63.	Cadaveric Type	-Local -Shared
64.	Living Related Type	-HLA Identical -Haplo Identical -Haplo Dissimilar -Identical Twin
	Donor Data	
65.	Sex Code	-Male -Female
66.	Age at Transplant	Source: HCFA-2745, Item 22.
67.	Blood Group	-O -A -B -AB
68.	Race Code ESRD PMMIS	Posted from latest HCFA-2728 (10/81) or HCFA-2745 (1/82) received. Possible values -American Indian/Alaskan Native -Asian/Pacific Islander -Black -White -Unknown
69.	Ethnicity	-Hispanic Origin -Not of Hispanic origin
70.	Infections at Harvest: HBs AG Positive	-Yes -No -Unknown
71.	Infections at Harvest: CMV Antibody	-Yes -No -Unknown
72.	Infections at Harvest: Other Infections	-Positive sputum culture - gram negative bacteria -Positive urine culture greater than 10,000 per ml. -Positive urine culture greater than 1,000,000 per ml.

Exhibit A

Information	Description
72. Infections at Harvest: Other Infections (con.)	-Pneumonia - gram positive -Pneumonia - gram negative -Meningitis -Bacteremia during admission -All others -No -Unknown
73. Cancer at Time of Harvest	-Intracranial -Extracranial -None -Both
74. Haplotype	-Yes -No
75. Locus A1	
76. Locus A2	
77. Locus B1	
78. Locus B2	
79. Locus C1	
80. Locus C2	
81. Locus DR1	
82. Locus DR2	
83. Locus MB1	
84. Locus MB2	
85. BUN	
86. Serum Creatinine	
87. Warm Ischemia Time (Minutes)	
88. Cold Time (Hours)	
89. Cold Time (Minutes)	
90. Pulsatile Perfusion (Hours)	
91. Pulsatile Perfusion (Minutes)	

Information	Description
Pretreatment	
92. Steroids	
93. Diuretics	
94. Diuretics (Mannitol)	
95. Diuretics (Lasix)	
96. Cyclophosphamide	
97. Methylprednisolone and cyclophosphamide	
98. Heparin	
99. Other	
100. Time Prior to Harvest	Time prior to harvest cyclophosphamide, methyprednisolone and cyclophosphamide or heparin given to the donor. -Given 0-5 hours prior -Given 5 or more hours prior

Exhibit A

ESRD Quarterly Dialysis Record

Information	Description
ESRD QUARTERLY DIALYSIS RECORD	Each dialysis record represents an aggregation by provider of all dialysis claims received during a quarter. There may be multiple dialysis records for any given quarter depending on the number of providers submitting claims. Source: HCFA-2743 (1/77 - 3/81), HCFA-1483 (4/81 - Current)
1. Record Identification Code	Identifies the record format being processed.
2. Social Security Number and Beneficiary Identification Code	PMMIS internal format. Converted from HIM format. Full code is retained as beneficiary identification code.
3. Dialysis Information Post Date	Date most recent dialysis information was posted to PMMIS.
4. Dialysis Sequence Number	Two Digits (01-99). Ascending chronological sequence counter of dialysis records.
5. Year of Service	
6. Quarter of Service	Calendar quarter in which the service was rendered.
7. Dialysis Provider	Dialysis provider reporting medical evidence. Source: HCFA-2728, Item 18; HCFA-2742, Item 9.
Dialysis Session Data	
8. First Date of Service in Quarter	
9. Last Date of Service in Quarter	
10. Full Care in Unit	
11. Self-Care in Unit	

	Information	Description
	12. Self-Care Training	
	13. Home Care	
14.	Number of Input Records	Number of records merged to create quarterly record.
15.	Current Dialysis Type	Source: HCFA-1483, HCFA-2743 Most current (date of service) reported type of dialysis. -Hemodialysis -Peritoneal -Both -CAPD
16.	Units of Blood	Units of blood billed during quarter. Source: HCFA-1483
17.	Filler	
18.	Source of Dialysis Information	-HCFA-2743 -HCFA-1483 -Both
19.	Dialysis Setting	-Full Care Unit -Self-Care Unit -Self-Care Training -Home
20.	Provider Certification Code	-Not Used -Dialysis Center -Hospital-based Facility -Non-Hospital Facility -Transplant/Dialysis Center -Inpatient Care Only -Not Certified

Exhibit A

ESRD Inpatient Stay Record

Information	Description
ESRD PMMIS INPATIENT STAY RECORD	PMMIS does not include records for 1 day stays. Source: HCFA-1450, HCFA-1453
1. Record Identification Code	Identifies the record format being processed.
2. Social Security Number and Beneficiary Identification Code	PMMIS internal format. Converted from HIM format. Full code is retained as beneficiary identification code.
3. Inpatient Stay Record Post Date	Date the inpatient stay information was posted to the PMMIS.
4. Stay Sequence Counter	Chronological sequence number of the stay.
5. Provider Number	Identifier for the provider of service.
6. Date of Admission	Julian date of admission to the provider.
7. From Date	Julian date of first service.
8. Through Date	Julian date for last service on bill submitted.
9. Patient Status Code	-Discharge -Died -Still Patient -Visits Exhausted (HHA Only)
10. Diagnosis Code	ICD-9-CM, left justified, blank filled.
11. Additional Diagnosis Indicator	Indicates the presence of additional diagnosis on bill. -No -Yes -Unknown
12. Surgical Procedure Code	
13. Date of Surgery	Julian date of beneficiary's surgery.
14. Additional Surgery Indicator	Indicates the presence of additional surgery on the bill.

	Information	Description
14.	Additional Surgery Indicator (con.)	-No surgery involved -No additional procedure -Yes, additional procedure -Unknown
15.	Number of Dialysis Sessions	
16.	Type of Inpatient Dialysis	-Hemodialyis -Peritoneal -Both
17.	Transplant During This Stay	Source: HCFA-1450, HCFA-1453, HCFA-2745
18.	Completeness of Stay Record	-Incomplete -Complete -Discharge
19.	Type of Medical Coding	-ICDA-8 -ICD-9-CM
20.	Kidney Acquisition Charge	Amount from inpatient bill.

Exhibit B

Facility Survey

Information	Description
Provider Data	
1. Provider Number	Facility identification number.
2. Provider Name	Name of facility.
3. Street Address	Street address of facility.
4. City	City of provider.
5. State	State abbreviation.
6. ZIP	5 position ZIP code.
7. Maintenance Hemo	Code to indicate staff-assisted hemodialysis at facility.
8. Maintenance Peri	Code to indicate staff-assisted peritoneal dialysis at facility.
9. Self-Care Hemo	Code to indicate in-unit self-care hemodialysis at facility.
10. Self-Care Peri	Code to indicate in-unit self-care peritoneal dialysis at facility.
11. Training Hemo	Code to indicate hemodialysis training at facility.
12. Training Peri	Code to indicate peritoneal dialysis training at facility.
13. CAPD Indicator	Indicates CAPD (continuous ambulatory peritoneal dialysis).
14. Total Stations	Total number of dialysis stations at facility. (Not always current.)
15. Certification Date	MMDDYY - Date of certification to provide renal services.
16. Certification Type	Code indicating type of facility certification. -Transplant Center -Dialysis Center -Dialysis Facility Hospital

	Information	Description
16.	Certification Type (con.)	-Dialysis Facility -Transplant and Dialysis Center -Inpatient Care Only
17.	Survey Cert	Certification type used for Facility Survey purposes.
18.	Prior Cert Date	MMDDYY of prior certification.
19.	Prior Cert Type	
20.	Termination Date	MMDDYY of facility termination.
21.	Termination Reason	Reason facility terminated, blank if no termination. -Involuntary withdrawal -Failure to meet health and safety standards -Failure to meet minimum utilization rates (MUR) -Failure to meet need requirement -Closed -Other
22.	Prior Term Date	MMDDYY of prior termination.
23.	Prior Term Reason	-Involuntary withdrawal -Failure to meet health and safety standards -Failure to meet minimum utilization rates (MUR) -Failure to meet need requirement -Closed -Other
24.	Medicare Cert Date	MMDDYY of approval for reimbursement of Medicare services.
25.	Intermediary	Identification number of current fiscal intermediary authorized to process bills from this provider.
26.	ESRD Network	Renal network number of the provider.
27.	Region	HCFA Regional Office Code.

Exhibit B

	Information	Description
28.	MSA	FIPS MSA number (4 positions) 5th Position = Size -1 million or more -250,000 to 999,999 -100,000 to 249,999 -Less than 100,000 Note: Size not completed.
29.	SSA County Code	Geographic code assigned by SSA standards.
30.	FIPS	Geographic code assigned by FIPS standards (Federal Information Processing Standard Code).
31.	Backup Provider	Backup dialysis provider - completed for free-standing facilities.
32.	Cross Refer No.	For internal use only.
33.	Convert No.	Indicates provider number for either change of ownership, transfer of stations, or number change
34.	FY-end	MMDD of fiscal year end.
35.	Reimbursement	Method of Reimbursement -Alternative Method: HCFA/Facility agreement to be paid on monthly basis. -Initial Method: Payment on fee-for-service basis. -Blank if not present.
36.	MUR Dialysis	Current Dialysis MUR -Conditional -Exceptional -Unconditional
37.	MUR Transplant	Current Transplant MUR- -Conditional -Exceptional -Unconditional
38.	Chain Indicator	Chain Indicator Assigned - Alpha (See Attachment 1)

Information	Description
39. Type Ownership	Type of Ownership -Individual - For Profit -Partnership - For Profit -Corporation - For Profit -Other - For Profit -Individual - Not For Profit -Partnership - Not For Profit -Corporation - Not For Profit -Other - Not For Profit -State-Government Non-Federal -County-Government Non-Federal -City-Government Non-Federal -City/County-Government Non-Federal -Hospital District/Authority-Government Non-Federal -Other - Government Non-Federal -Veterans Administration - Government Federal -Public Health Service - Government Federal -Military - Government Federal -Other - Government Federal
40. Skeleton Record	For internal use only.
41. Change Date	MMYY of last information change in file.
Dialysis Patients	
42. Beginning In-Unit	In-unit patients receiving care at beginning of Survey period.
43. Beginning Home	Home patients receiving care at beginning of Survey period.
44. Beginning Total	Total patients receiving care at beginning of Survey period.
45. In-Unit First Start	In-unit started for first time ever - addition during Survey period.
46. Home First Start	Home started for first time ever - addition during Survey period.
47. In-Unit Restarted	In-unit restarted - addition during Survey period.
48. Home Restarted	Home restarted - addition during Survey period.

Exhibit B

Information	Description
49. In-Unit Transferred In	In-unit transferred from other dialysis unit - addition during Survey period.
50. Home Transferred In	Home transferred from other dialysis unit - addition during Survey period.
51. In-Unit Transplant Return	In-unit returned after transplantation - addition during Survey period.
52. Home Transplant Return	Home returned after transplantation - addition during Survey period.
53. In-Unit Deaths	In-unit deaths - losses during Survey period.
54. Home Deaths	Home deaths - losses during Survey period.
55. In-Unit Recovered	In-unit recovered kidney function -losses during Survey period.
56. Home Recovered	Home recovered kidney function - losses during Survey period.
57. In-Unit Received Transplant	In-unit received transplant - losses during Survey period.
58. Home Received Transplant	Home received transplant - losses during Survey period.
59. In-Unit Transferred Out	In-unit transferred to other dialysis unit - losses during Survey period.
60. Home Transferred Out	Home transferred to other dialysis unit - losses during Survey period.
61. In-Unit Discontinued	In-unit discontinued dialysis - losses during Survey period.
62. Home Discontinued	Home discontinued dialysis-losses during Survey period.
63. In-Unit Other	In-unit other (LTFU) - losses during Survey period.
64. Home Other	Home other (LTFU) - losses during Survey period.
65. Staff Hemo	Staff-assisted hemodialysis patients receiving care at end of Survey period.

Information	Description
66. Staff Peritoneal	Staff-assisted peritoneal dialysis patients receiving care at end of Survey period.
67. In-Unit Self Hemo	In-unit self-dialysis hemodialysis patients receiving care at end of Survey period.
68. In-Unit Self Peri	In-unit self-dialysis peritoneal dialysis patients receiving care at end of Survey period.
69. Hemo Training	Self-dialysis training hemodialysis patients receiving care at end of Survey period.
70. Peri Training	Self-dialysis training peritoneal dialysis patients receiving care at end of Survey period.
71. CAPD Self-dialysis	CAPD patients receiving care at end of Survey period.
72. CCPD	Self-dialysis CCPD patients receiving care at end of Survey period.
73. Total In-Unit	Total in-unit patients receiving care at end of Survey period.
74. Home Hemo	Hemodialysis home patients receiving care at end of Survey period.
75. Home Peri	Peritoneal dialysis home patients receiving care at end of Survey period.
76. Home CAPD	CAPD home patients receiving care at end of Survey period.
77. Home CCPD	CCPD home patients receiving care at end of Survey period.
78. Total Home	Total home patients receiving care at end of Survey period.
79. Total Patients	Total patients receiving care at end of Survey period.
80. Medicare Enrolled	Currently enrolled in Medicare - patient eligibility status end of Survey period.

Exhibit B

Information	Description
81. Application Pending	Medicare application pending - patient eligibility status end of Survey period.
82. Non-Medicare	Non-Medicare - patient eligibility status end of Survey period.
83. Home Hemo Completed Training	Home hemodialysis self-dialysis patients completing training.
84. In-Unit Hemo Completed Training	In-unit self hemodialysis - self-dialysis patients completing training.
85. Home Peri Completed Training	Home peritoneal dialysis - self-dialysis patients completing training.
86. In-Unit Peri Completed Training	In-unit self peritoneal dialysis - self-dialysis patients completing training.
87. CAPD Completed Training	CAPD self-dialysis patients completing training.
88. CCPD Completed Training	CCPD self-dialysis patients completing training.
89. Transient Patients Treated	Transient patients treated during Survey period.
Dialysis Treatments	
90. Transient Treatments	Number of transient patient treatments during Survey period.
91. Inpatient Hemo Treatments	Number of inpatient hemodialysis treatments.
92. Outpatient SA Hemo Treatments	Number of outpatient staff-assisted hemodialysis treatments.
93. Outpatients Self Hemo Treatments	Number of outpatient self-hemodialysis treatments.
94. Inpatient Peri Treatments	Number of inpatient peritoneal treatments.
95. Outpatient SA Peri Treatments	Number of outpatient staff-assisted peritoneal treatments.
96. Outpatient Self Peri Treatments	Number of outpatient self-peritoneal treatments.

Information	Description
97. Hemo Training Treatments	Number of hemodialysis training treatments.
98. Peri Training Treatments	Number of peritoneal dialysis training treatments.
99. CAPD Training Treatments	CAPD training treatments.
100. CCPD Training Treatments	CCPD training treatments.
Kidney Transplants	
101. Patients Transplanted	Patients who received transplant at this facility.
102. Medicare Patients Transplanted	Patients transplanted and currently enrolled in Medicare.
103. Medicare Application Pending	Patients transplanted and Medicare application pending.
104. Non-Medicare Transplants	Patients transplanted and non-Medicare.
105. Living Donor Transplant	Living donor transplants performed.
106. Cadaveric Donor Transplants	Cadaveric donor transplants performed.
107. Total Transplants	Total transplants performed.
108. Dialysis Awaiting Transplant	Dialysis patients awaiting transplant.
109. Non-Dialysis Awaiting Transplant	Non-dialysis patients awaiting transplant.
Disposition of Kidneys	
110. Harvested and Transplanted	Cadaver kidneys harvested and transplanted at this facility.
111. Harvested and Sent	Cadaver kidneys harvested at this facility and sent to another facility.
112. Harvested and Not Used	Cadaver kidneys harvested at this facility and not used.
113. Total Harvested	Total cadaver kidneys harvested at this facility.
114. Obtained and Transplanted	Cadaver kidneys obtained from another transplant hospital/OPA and transplanted at this facility.

Exhibit B

Information	Description
115. Obtained and Sent	Cadaver kidneys obtained from another transplant hospital/OPA and sent to another facility.
116. Obtained and Not Used	Cadaver kidneys obtained from another transplant hospital/OPA and not used.
117. Total Obtained	Total cadaver kidneys obtained from another transplant hospital/OPA.
118. Obtained and Transplanted	Cadaver kidneys obtained from non-transplant hospital and transplanted at this facility.
119. Obtained and Sent	Cadaver kidneys obtained from non-transplant hospital and sent to another facility.
120. Obtained and Not Used	Cadaver kidneys obtained from non-transplant hospital and not used.
121. Total Obtained	Total cadaver kidneys obtained from non-transplant hospital.
122. Total Cadaver Transplanted	Total cadaver kidneys transplanted at this facility.
123. Total Cadaver Sent	Total cadaver kidneys sent to another facility.
124. Total Not Used	Total cadaver kidneys not used.
125. Survey Year	Year of Survey.

CHAIN ORGANIZATIONS

Region I (Boston)

AA - National Medical Care, Boston, Massachusetts

Region II (New York)

BA - National Nephrology Foundation, New York, New York

Region III (Philadelphia)

DA - Mid-Atlantic Nephrology Center, Washington, D.C.
DB - Area Cooperating Dialysis Centers, Ltd., Wilmington, Delaware
DC - Medical Administrative Service, Inc., Forestville, Maryland
DD - Clinical Renal Associates, Ltd., Downington, Pennsylvania
DE - Dialysis Inc., Lansdown, Pennsylvania
DF - Danville Urologic, Inc., Danville, Virginia
DG - Emporia Dialysis Center, Inc., Emporia, Virginia
DH - Dr. Charles H. and Stephanie T. Brooks, Harrisonburg, Virginia
DI - Security Health Services, Inc., Warrenton, Virginia
DJ - Nephrology Associates, Inc., Bryn Mawr, Pennsylvania

Region IV (Atlanta)

GA - Dialysis Corporation of America, Miami, Florida
GB - Nephrologists Associates, P.A., Miami, Florida
GC - South Artificial Kidney Center, Inc., Miami, Florida
GD - Consolidated Health Services, Atlanta, Georgia
GE - Augusta Dialysis Center, Inc., Augusta, Georgia
GF - Southern Healthcare Affiliates, Comilla, Georgia
GG - Dr. Leslie Feinsmith, Jonesboro, Georgia
GH - Southern Dialysis Centers, Inc., Norcross, Georgia
GI - Hattiesburg Clinic, P.A., Hattiesburg, Mississippi
GJ - Kidney Care, Inc., Jackson, Mississippi
GK - Metrolina Kidney Center, Inc., Charlotte, North Carolina
GL - Southern Management, Grier, South Carolina
GM - East Tennessee Dialysis Center, Johnson City, Tennessee
GN - Fort Sanders Kidney Center, Knoxville, Tennessee
GO - Dialysis Clinics, Inc., Nashville, Tennessee
GP - Renal Dialysis, Inc., Nashville, Tennessee
GQ - North Mississippi Health Services, Tupelo, Mississippi
GR - Shirley C. Rowland, Macon, Georgia

Region V (Chicago)

LA - Dialysis Centers, Ltd., Chicago, Illinois
LB - North Central Dialysis Centers, Chicago, Illinois
LC - W. Suburban Kidney Center, S.C., Oak Park, Illinois

LD - Community Ltd. Care Dialysis Center, Cincinnati, Ohio
LE - The Community Dialysis Centers, Inc., Cleveland, Ohio
LF - Greenfield Health Systems Corp. (Henry Ford Health Care Corp.), Detroit, Michigan

Region VI (Dallas)

PA - Dr. Saeed Ahmed, Kenner, Louisiana
PB - Natchitoches Dialysis Facilities, Inc., Natchitoches, Tennessee (XR D.C.)
PC - Midwest Dialysis, Oklahoma City, Oklahoma
PD - Austin Diagnostic, Austin, Texas
PE - Scott and White Clinic, Inc., Temple, Texas

Region VII (Kansas City)

Region VIII (Denver)

TA - Division of Artificial Organs, Home Dialysis Training Center, University of Utah, Salt Lake City, Utah
TB - Dialysystems Inc., Midvale, Utah

Region IX (San Francisco)

UA - Dialysis Foundations of Southern Arizona, Inc., Tucson, Arizona
UB - Hemodialysis, Inc., Dialysis Network International, Glendale, California
UC - East Bay Dialysis Medical Clinics, Inc., Hayward, California
UD - Medical Ambulatory Care (Hillhaven Corporation), National Medical Enterprises, Inc., Los Angeles, California
UE - USHAWL, Inc., Los Angeles, California
UF - Satellite Dialysis Center, Inc., Menlo Park, California
UG - New West Dialysis Clinic, Sacramento, California
UI - Community Psychiatric Centers, Community Dialysis Centers, Dialysis Operations, Inc., Santa Ana, California
UJ - Dialysis Services, Phoenix, Arizona
UK - Intercontinental Medical Services, Inc., Honolulu, Hawaii

Region X (Seattle)

XA - Dr. Christopher Blagg, Seattle, Washington

XI. Hospital Cost Report Information System (HCRIS)

Introduction

HCRIS is the national data base for Medicare hospital cost report data. The data base contains specific financial and statistical cost report data from Medicare certified hospitals and hospital/health care facility complexes beginning with hospital fiscal years ending on or after January 1, 1982. HCRIS also contains Title V and/or Title XIX data to the extent that the Medicare Fiscal Intermediaries (FI's) are responsible for processing and settling the hospitals' cost reports for these Federal programs. The HCRIS data base will include, by the government's 1986 fiscal year end (FYE), data from the following Medicare cost reports:

HCFA-2552-81 (FYE's on or after January 1, 1982, and before October 1, 1983)

HCFA-2552-83 (TEFRA--Cost reporting periods beginning on or after October 1, 1982, and before October 1, 1983).

HCFA-2552-84 (PPS-1--Cost reporting periods beginning on or after October 1, 1983, and before October 1, 1984).

HCRIS is not one but three distinct systems, one for each issuance of the HCFA-2552 (HCFA-2552-81, HCFA-2552-83 and HCFA-2552-84). Each time a new version of a hospital cost report is issued by HCFA, a new HCRIS system is required based on cost report format and HCFA data users' needs. The HCFA-2552-81 system includes the underlying base period cost report used in the final PPS and/or TEFRA payment rate and the HCFA-1007 (form for computing target amount per discharge under PPS and TEFRA).

Source Data--Hospital Cost Reports

The cost report is a variable document which must accommodate large teaching hospitals as well as small rural hospitals. The number of cost centers in each can vary from 15 to more than 300. Each cost report can comprise up to 3,600 60-character records or 216,000 total characters. More than 10,000 cost reports are processed through HCRIS annually, including initial submissions, resubmissions, and reopenings.

HCRIS tracks the initial receipt and subsequent processing status of all Medicare hospital cost reports, edits and reconciles inconsistencies in data received to assure quality of data, creates and updates the data base, and generates routine and user specific reports.

Current HCRIS Design

Cost report data are received from FI's in either automated format or in hard copy. In the automated format, FI's use HCRIS approved Automated Desk Review vendor software to create and transmit HCRIS data files using either time-sharing networks, diskettes, or tapes created from the FI's own mainframe computer. Each mode of transmission requires different HCRIS operating procedures and controls.

Some cost reports, due to size or method of cost apportionment, are sent to HCRIS in hard copy. The necessary cost data from the manual reports must then be extracted and special software must be written by the HCRIS staff to input the data onto a separate data base.

Derivative Files

HCRIS generates both routine and user-specific reports. A minimum data set has been designed for each of the three data bases to date. (See Exhibit A for a copy of the 2552-84 minimum data set record specifications. Similar data sets are also available for the HCFA Forms 2552-83 and 2552-81). These data sets are intended to satisfy a majority of HCRIS data requests. In addition, customized programming is available upon request to meet user-specific needs.

HOSPITAL COST DATA FROM HCFA FORM 2552-84 FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 1983, AND BEFORE OCTOBER 1, 1984

IDENTIFYING AND INFORMATIONAL DATA
SOURCE: FORM HCFA-2552-84 WORKSHEET S-2

Field Name		Line(s)	Columns(s)
F1	Provider Number--Hospital	1a	2
F2	Provider Number--Subprovider I	1b	2
F3	Provider Number--Subprovider II	1c	2
F4	Provider Number--Swing Bed SNF	1d	2
F5	Provider Number--Swing Bed ICF	1e	2
F6	Provider Number--Hospital Based SNF	1f	2
F7	Provider Number--Hospital Based ICF	1g	2
F8	Provider Number--Hospital Based Other Long Term Care Facility	1h	2
F9	Provider Number--Hospital Based HHA	1i	2
F10	Provider Number--Hospital Based CORF	1j	2
F11	Provider Number--Hospital Based ASC	1k	2
F12	Provider Number--Hospital Based Hospice	1l	2
F13	Hospital Name	1a	1
F14	Hospital Payment System Under Medicare (P = PPS, T = TEFRA, O = Other)	1a	5
F15	Cost Reporting Period Beginning Date (YYMMDD)	2	2
F16	Cost Reporting Period Ending Date (YYMMDD)	2	3
F17	Number of Months in the Cost Reporting Period		
F18	Type of Control (See Table I for Key)	3	1
F19	Type of Hospital (See Table II for Key)	4a	1
F20	Management/Support Services Purchased (Y/N)	5a	1
F21	Funded Depreciation (Y/N)	6g	1
F22	County Code		
F23	MSA Code (SSA)		
F24	MSA Code (FIPS)		
F25	Fiscal Intermediary Number		
F26	Cost Report Status (See Table III for Key)		
F27	All Inclusive Rate Provider (Y/N)		
F28	New Provider (Y/N)		

STATISTICAL DATA
SOURCE: FORM HCFA-2552-84 WORKSHEET S-3

Field Name		Line(s)	Columns(s)
F29	General Service Beds Available, End of Period	1	1
F30	General Service Beds Days Available (Excl. Newborn)	1	2
F31	Intensive Care Beds Available, End of Period	2	
F32	Intensive Care Beds Days Available (Excl. Newborn)	2	2

EXHIBIT A

STATISTICAL DATA (CONTINUED)
SOURCE: FORM HCFA-2552-84 WORKSHEET S-3

Field Name		Line(s)	Columns(s)
F33	Coronary Care Beds Available, End of Period	3	1
F34	Coronary Care Beds Days Available (Excl. Newborn)	3	2
F35	Other Special Care Unit Beds Available, End of Period	4-6	1
F36	Other Special Care Unit Bed Days Available (Excl. Newborn)	4-6	2
F37	Total Beds Available in the Facility, End of Period	18	1
F38	Total Bed Days Available in the Facility	18	2
F39	Number of Full-Time Interns and Residents--Hospital	8	3
F40	Number of Full-Time Interns and Residents--Facility	18	3
F41	Average Number of Employees (FTE's)--Hospital	8	6
F42	Average Number of Employees (FTE's)--Facility	18	6
F43	Average Number of Nonpaid Workers (FTE's)--Hospital	8	7
F44	Average Number of Nonpaid Workers (FTE's)--Facility	18	7
F45	Medicare Discharges (Incl. Deaths, Excl. Newborn)	8	9
F46	Medicaid Discharges (Incl. Deaths, Excl. Newborn)	8	10
F47	Total Discharges (Incl. Deaths, Excl. Newborn)	8	11

HOSPITAL INPATIENT DAYS
SOURCE: FORM HCFA-2552-84 WORKSHEET D-1, PARTS I AND II

Field Name		Line(s)	Columns(s)
F48	Total Routine Days (Incl. Private Room and Swing-Bed Days, Excl. Newborn Days)	1	1
F49	Total Routine Days (Incl. Private Room Days, Excl. Swing-Bed and Newborn Days)	2	1
F50	Total Title XVIII Routine Days (Incl. Private Room Days Excl. Swing-Bed and Newborn Days)	9	1
F51	Total Title XIX Routine Days (Incl. Private Room Days Excl. Swing-Bed and Newborn Days)	9	1
F52	Total Title XVIII Medically Necessary Days (Excl. Swing-Bed Days)--Routine	14	1
F53	Total Title XIX Medically Necessary Days (Excl. Swing-Bed Days)--Routine	14	1
F54	Intensive Care Total Inpatient Days	43	b
F55	Intensive Care Total Title XVIII Inpatient Days	43	d
F56	Intensive Care Total Title XIX Inpatient Days	43	d
F57	Coronary Care Total Inpatient Days	44	b
F58	Coronary Care Total Title XVIII Inpatient Days	44	d
F59	Coronary Care Total Title XIX Inpatient Days	44	d
F60	Other Special Care Total Inpatient Days	45-47	b
F61	Other Special Care Total Title XVIII Inpatient Days	45-47	d
F62	Other Special Care Total Title XIX Inpatient Days	45-47	d

TOTAL OPERATING COSTS
SOURCE: FORM HCFA-2552-84 WORKSHEET A

Field Name	Line(s)	Columns(s)
F63 Depreciation--Buildings and Fixtures, Before Reclassification or Adjustment	1	2
F64 Depreciation--Movable Equipment, Before Reclassification or Adjustment	2	2
F65 Direct Salaries--All General Service Cost Centers	3-24	1
F66 Direct Salaries--All Hospital Inpatient Cost Centers	25-30	1
F67 Direct Salaries--All Other Inpatient Cost Centers	31-36	1
F68 Direct Salaries--All Ancillary Service Cost Centers	37-59	1
F69 Direct Salaries--All Outpatient Service Cost Centers	60-62	1
F70 Direct Salaries--All Other Reimbursable Cost Centers	63-82	1
F71 Direct Salaries--All Special Purpose Cost Centers	83-94	1
F72 Direct Salaries--All Nonreimbursable Cost Centers	96-100	1
F73 Other Direct Cost--All General Service Cost Centers	1-24	2
F74 Other Direct Cost--All Hospital Inpatient Cost Centers	25-30	2
F75 Other Direct Cost--All Other Inpatient Cost Centers	31-36	2
F76 Other Direct Cost--All Ancillary Service Cost Centers	37-59	2
F77 Other Direct Cost--All Outpatient Service Cost Centers	60-62	2
F78 Other Direct Cost--All Other Reimbursable Cost Centers	63-82	2
F79 Other Direct Cost--All Special Purpose Cost Centers	83-94	2
F80 Other Direct Cost--All Nonreimbursable Cost Centers	96-100	2

SUMMARY OF CHANGES IN CAPITAL ASSET BALANCES
SOURCE: FORM HCFA-2552-84 WORKSHEET A-7

Field Name	Line(s)	Columns(s)
F81 Beginning Balance--Land	1a	1
F82 Purchases--Land	1a	2
F83 Donations--Land	1a	3
F84 Disposals and Retirements--Land	1a	5
F85 Beginning Balance--Land Improvements	1b	1
F86 Purchases--Land Improvements	1b	2
F87 Donations--Land Improvements	1b	3
F88 Disposals and Retirements--Land Improvements	1b	5
F89 Beginning Balance--Buildings and Fixtures	1c	1
F90 Purchases--Buildings and Fixtures	1c	2
F91 Donations--Buildings and Fixtures	1c	3
F92 Disposals and Retirements--Buildings and Fixtures	1c	5
F93 Beginning Balance--Building Improvements	1d	1
F94 Purchases--Building Improvements	1d	2
F95 Donations--Building Improvements	1d	3
F96 Disposals and Retirements--Building Improvements	1d	5
F97 Beginning Balance--Fixed Equipment	1e	1
F98 Purchases--Fixed Equipment	1e	2

EXHIBIT A

SUMMARY OF CHANGES IN CAPITAL ASSET BALANCES (CONTINUED)
SOURCE: FORM HCFA-2552-84 WORKSHEET A-7

Field Name	Line(s)	Columns(s)
F99 Donations--Fixed Equipment	1e	3
F100 Disposals and Retirements--Fixed Equipment	1e	5
F101 Beginning Balance--Movable Equipment	1f	1
F102 Purchases--Movable Equipment	1f	2
F103 Donations--Movable Equipment	1f	3
F104 Disposals and Retirements--Movable Equipment	1f	5

ADJUSTMENTS TO TOTAL OPERATING COSTS
SOURCES: FORM HCFA-2552-84 WORKSHEETS A-8 AND A-8-2

Field Name	Line(s)	Columns(s)
F105 Related Organization Transaction	13	2
F106 Physicians' Remuneration--Total	101	1
F107 Physicians' Remuneration--Professional Component	101	2
F108 Physicians' Remuneration--Provider Component	101	3
F109 Number of Physicians' Hours--Provider Component	101	5
F110 RCE Limit--Total	101	6
F111 RCE Disallowance--Total	101	7
F112 Adjustment for Physicians' Professional Services and Cost in Excess of RCE Limits	101	8

REIMBURSABLE OPERATING COSTS, BEFORE COST ALLOCATION
SOURCE: FORM HCFA-2552-84 WORKSHEET B, PART I

Field Name	Line(s)	Column(s)
F113 Depreciation--Buildings and Fixtures, After Reclassification and Adjustment	1	0
F114 Depreciation--Movable Equipment, After Reclassification and Adjustment	2	0
F115 All General Service Cost Centers	1-24	0
F116 All Hospital Inpatient Cost Centers	25-30	0
F117 All Other Inpatient Cost Centers	31-36	0
F118 All Ancillary Service Cost Centers	37-59	0
F119 All Outpatient Service Cost Centers	60-62	0
F120 All Other Reimbursable Cost Centers	63-82	0
F121 All Special Purpose Cost Centers	83-94	0
F122 All Nonreimbursable Cost Centers	96-100	0
F123 Total Reimbursable Costs	103	0

MEDICAL EDUCATION COSTS
SOURCE: FORM HCFA-2552-84 WORKSHEET B, PART I

Field Name		Line(s)	Columns(s)
	****NURSING SCHOOL****		
F124	Total Nursing School Costs	103	20
	****INTERNS and RESIDENTS IN APPROVED PROGRAMS****		
F125	All Paramedical Education Programs	22-24	21
F126	Adults and Pediatrics (General Routine Care)	25	21
F127	Intensive Care Unit	26	21
F128	Coronary Care Unit	27	21
F129	All Other Special Care Units	28-30	21
F130	Subprovider I	31	21
F131	Subprovider II	32	21
F132	Nursery	33	21
F133	Skilled Nursing Facility	34	21
F134	Intermediate Care Facility	35	21
F135	Other Long Term Care Facility	36	21
F136	Operating Room	37	21
F137	Recovery Room	38	21
F138	Delivery Room and Labor Room	39	21
F139	Anesthesiology	40	21
F140	Radiology--Diagnostic	41	21
F141	Radiology--Therapeutic	42	21
F142	Radioisotope	43	21
F143	Laboratory	44	21
F144	Whole Blood and Packed Red Blood Cells	46	21
F145	Blood Storing, Processing, and Transfusion	47	21
F146	Intravenous Therapy	48	21
F147	Respiratory Therapy	49	21
F148	Physical Therapy	50	21
F149	Occupational Therapy	51	21
F150	Speech Pathology	52	21
F151	Electrocardiology	53	21
F152	Electroencephalography	54	21
F153	Medical Supplies Charged to Patients	55	21
F154	Drugs Charged to Patients	56	21
F155	Renal Dialysis	57	21
F156	All Other Inpatient Ancillary Cost Centers	58-59	21
F157	Outpatient Clinic	60	21
F158	Emergency	61	21
F159	All Other Outpatient Service Cost Centers	62	21
F160	Home Program Dialysis	63	21
F161	Ambulance Services	64	21
F162	Durable Medical Equipment--Rented	65	21
F163	Durable Medical Equipment--Sold	66	21
F164	All Other Reimbursable Cost Centers	67-68	21
F165	Home Program Dialysis Equipment--100 percent Medicare	69	21
F166	Intern-Resident Service (Not in Approved Programs)	70	21

EXHIBIT A

COST OF INTERNS AND RESIDENTS IN APPROVED PROGRAMS (CONTINUED)
SOURCE: FORM HCFA-2552-84 WORKSHEET B, PART I

Field Name	Line(s)	Column(s)
F167 Administrative and General--HHA	71	21
F163 Skilled Nursing Care--HHA	72	21
F169 Physical Therapy--HHA	73	21
F170 Occupational Therapy--HHA	74	21
F171 Speech Pathology--HHA	75	21
F172 Medical Social Services--HHA	76	21
F173 Home Health Aide--HHA	77	21
F174 Medical Appliances/DME-Rented--HHA	78	21
F175 Medical Appliances/DME-Sold--HHA	79	21
F176 Home Delivered Meals--HHA	80	21
F177 Other Home Health Services--HHA	81	21
F178 CORF	82	21
F179 Kidney Acquisition	83	21
F180 Liver Acquisition	84	21
F181 Other Organ Acquisition	85	21
F182 Ambulatory Surgical Center	91	21
F183 Hospice	92	21
F184 All Other Special Purpose Cost Centers	93-94	21
F185 All Nonreimbursable Cost Centers	96-100	21
F186 Total Interns and Residents Costs (Approved Programs)	103	21
****PARAMEDICAL EDUCATION****		
F187 Total Paramedical Education Costs	103	22-24

TOTAL CAPITAL - RELATED COSTS
SOURCE: FORM HCFA-2552-84 WORKSHEET B, PART II

Field Name	Line(s)	Column(s)
F188 Adults and Pediatrics (General Routine Care)	25	25
F189 Intensive Care Unit	26	25
F190 Coronary Care Unit	27	25
F191 All Other Special Care Units	28-30	25
F192 Subprovider I	31	25
F193 Subprovider II	32	25
F194 Nursery	33	25
F195 Skilled Nursing Facility	34	25
F196 Intermediate Care Facility	35	25
F197 Other Long Term Care Facility	36	25
F198 Operating Room	37	25
F199 Recovery Room	38	25
F200 Delivery Room and Labor Room	39	25
F201 Anesthesiology	40	25
F202 Radiology--Diagnostic	41	25

TOTAL CAPITAL - RELATED COSTS (CONTINUED)
SOURCE: FORM HCFA-2552-84 WORKSHEET B, PART II

Field Name	Line(s)	Column(s)
F203 Radiology--Therapeutic	42	25
F204 Radioisotope	43	25
F205 Laboratory	44	25
F206 Whole Blood and Packed Red Blood Cells	46	25
F207 Blood Storing, Processing, and Transfusion	47	25
F208 Intravenous Therapy	48	25
F209 Respiratory Therapy	49	25
F210 Physical Therapy	50	25
F211 Occupational Therapy	51	25
F212 Speech Pathology	52	25
F213 Electrocardiology	53	25
F214 Electroencephalography	54	25
F215 Medical Supplies Charged to Patients	55	25
F216 Drugs Charged to Patients	56	25
F217 Renal Dialysis	57	25
F218 All Other Inpatient Ancillary Cost Centers	58-59	25
F219 Outpatient Clinic	60	25
F220 Emergency	61	25
F221 All Other Outpatient Service Cost Centers	62	25
F222 All Other Reimbursable Cost Centers	63-82	25
F223 All Special Purpose Cost Centers	83-85, 91-94	25
F224 All Nonreimbursable Cost Centers	96-100	25
F225 Total Capital - Related Costs	103	25

COSTS AFTER STEPDOWN
SOURCES: FORM HCFA-2552-84 WORKSHEET C AND WORKSHEET B, PART I

Field Name	Line(s)	Column(s
F226 Adults and Pediatrics (General Routine Care)	25	1
F227 Intensive Care Unit	26	1
F228 Coronary Care Unit	27	1
F229 All Other Special Care Units	28-30	1
F230 Subprovider I	31	1
F231 Subprovider II	32	1
F232 Nursery	33	1
F233 Skilled Nursing Facility	34	1
F234 Intermediate Care Facility	35	1
F235 Other Long Term Care Facility	36	1
F236 Operating Room	37	1
F237 Recovery Room	38	1
F238 Delivery Room and Labor Room	39	1
F239 Anesthesiology	40	1
F240 Radiology--Diagnostic	41	1
F241 Radiology--Therapeutic	42	1
F242 Radioisotope	43	1

COSTS AFTER STEPDOWN (CONTINUED)
SOURCES: FORM HCFA-2552-84 WORKSHEET C AND WORKSHEET B, PART I

Field Name	Line(s)	Column(s)
F243 Laboratory	44	1
F244 PBP Clinic Lab Services-Program Only	45	1
F245 Whole Blood and Packed Red Blood Cells	46	1
F246 Blood Storing, Processing, and Transfusion	47	1
F247 Intravenous Therapy	48	1
F248 Respiratory Therapy	49	1
F249 Respiratory Therapy Limit Adjustment	49	2
F250 Physical Therapy	50	1
F251 Physical Therapy Limit Adjustment	50	2
F252 Occupational Therapy	51	1
F253 Speech Pathology	52	1
F254 Electrocardiology	53	1
F255 Electroencephalography	54	1
F256 Medical Supplies Charged to Patients	55	1
F257 Drugs Charged to Patients	56	1
F258 Renal Dialysis	57	1
F259 All Other Inpatient Ancillary Cost Centers	58-59	1
F260 Outpatient Clinic	60	1
F261 Emergency	61	1
F262 All Other Outpatient Service Cost Centers	62	1
F263 All Other Reimbursable Cost Centers	63-68	1
F264 Total Hospital Reimbursable Costs After Stepdown	101	1
F265 All Special Purpose Cost Centers	83-85, 91-94	25
F266 All Nonreimbursable Cost Centers	96-100	25

TOTAL FACILITY ANCILLARY CHARGES
SOURCE: FORM HCFA-2552-84 WORKSHEET C

Field Name	Line(s)	Column(s)
F267 Operating Room	37	6
F268 Recovery Room	38	6
F269 Delivery Room and Labor Room	39	6
F270 Anesthesiology	40	6
F271 Radiology--Diagnostic	41	6
F272 Radiology--Therapeutic	42	6
F273 Radioisotope	43	6
F274 Laboratory	44	6
F275 PBP Clinic Lab Services-Program Only	45	6
F276 Whole Blood and Packed Red Blood Cells	46	6
F277 Blood Storing, Processing, and Transfusion	47	6
F278 Intravenous Therapy	48	6
F279 Respiratory Therapy	49	6
F280 Physical Therapy	50	6
F281 Occupational Therapy	51	6

TOTAL FACILITY ANCILLARY CHARGES (CONTINUED)
SOURCE: FORM HCFA-2552-84 WORKSHEET C

Field Name	Line(s)	Column(s)
F282 Speech Pathology	52	6
F283 Electrocardiology	53	6
F284 Electroencephalography	54	6
F285 Medical Supplies Charged to Patients	55	6
F286 Drugs Charged to Patients	56	6
F287 Renal Dialysis	57	6
F288 All Other Inpatient Ancillary Cost Centers	58-59	6
F289 Outpatient Clinic	60	6
F290 Emergency	61	6
F291 All Other Outpatient Service Cost Centers	62	6
F292 All Other Reimbursable Cost Centers	63-68	6

HOSPITAL ANCILLARY CHARGES, TITLE XVIII, PART A
SOURCE: FORM HCFA-2552-84 WORKSHEET D, PART I

Field Name	Line(s)	Column(s)
F293 Operating Room	37	2
F294 Recovery Room	38	2
F295 Delivery Room and Labor Room	39	2
F296 Anesthesiology	40	2
F297 Radiology--Diagnostic	41	2
F298 Radiology--Therapeutic	42	2
F299 Radioisotope	43	2
F300 Laboratory	44	2
F301 PBP Clinic Lab Services-Program Only	45	2
F302 Whole Blood and Packed Red Blood Cells	46	2
F303 Blood Storing, Processing, and Transfusion	47	2
F304 Intravenous Therapy	48	2
F305 Respiratory Therapy	49	2
F306 Physical Therapy	50	2
F307 Occupational Therapy	51	2
F308 Speech Pathology	52	2
F309 Electrocardiology	53	2
F310 Electroencephalography	54	2
F311 Medical Supplies Charged to Patients	55	2
F312 Drugs Charged to Patients	56	2
F313 Renal Dialysis	57	2
F314 All Other Inpatient Ancillary Cost Centers	58-59	2
F315 Outpatient Clinic	60	2
F316 Emergency	61	2
F317 All Other Outpatient Service Cost Centers	62	2
F318 All Other Reimbursable Cost Centers	63-68	2
F319 Operating Room	37	3
F320 Recovery Room	38	3
F321 Delivery Room and Labor Room	39	3

EXHIBIT A

HOSPITAL ANCILLARY CHARGES, TITLE XVIII, PART A (CONTINUED)
SOURCE: FORM HCFA-2552-84 WORKSHEET D, PART I

Field Name	Line(s)	Column(s)
F322 Anesthesiology	40	3
F323 Radiology--Diagnostic	41	3
F324 Radiology--Therapeutic	42	3
F325 Radioisotope	43	3
F326 Laboratory	44	3
F327 PBP Clinic Lab Services-Program Only	45	3
F328 Whole Blood and Packed Red Blood Cells	46	3
F329 Blood Storing, Processing, and Transfusion	47	3
F330 Intravenous Therapy	48	3
F331 Respiratory Therapy	49	3
F332 Physical Therapy	50	3
F333 Occupational Therapy	51	3
F334 Speech Pathology	52	3
F335 Electrocardiology	53	3
F336 Electroencephalography	54	3
F337 Medical Supplies Charged to Patients	55	3
F338 Drugs Charged to Patients	56	3
F339 Renal Dialysis	57	3
F340 All Other Inpatient Ancillary Cost Centers	58-59	3
F341 Outpatient Clinic	60	3
F342 Emergency	61	3
F343 All Other Outpatient Service Cost Centers	62	3
F344 All Other Reimbursable Cost Centers	63-68	3
F345 Total Inpatient Ancillary Costs	101	3

HOSPITAL ANCILLARY CAPITAL - RELATED COSTS, TITLE XVIII, PART A
SOURCE: FORM HCFA-2552-84 WORKSHEET D, PART II

Field Name	Line(s)	Column(s)
F346 Operating Room	37	5
F347 Recovery Room	38	5
F348 Delivery Room and Labor Room	39	5
F349 Anesthesiology	40	5
F350 Radiology--Diagnostic	41	5
F351 Radiology--Therapeutic	42	5
F352 Radioisotope	43	5
F353 Laboratory	44	5
F354 Whole Blood and Packed Red Blood Cells	46	5
F355 Blood Storing, Processing, and Transfusion	47	5
F356 Intravenous Therapy	48	5
F357 Respiratory Therapy	49	5
F358 Physical Therapy	50	5
F359 Occupational Therapy	51	5
F360 Speech Pathology	52	5
F361 Electrocardiology	53	5

HOSPITAL ANCILLARY CAPITAL - RELATED COSTS, TITLE XVIII, PART A (CONTINUED)
SOURCE: FORM HCFA-2552-84 WORKSHEET D, PART II

Field Name	Line(s)	Column(s)
F362 Electroencephalography	54	5
F363 Medical Supplies Charged to Patients	55	5
F364 Drugs Charged to Patients	56	5
F365 Renal Dialysis	57	5
F366 All Other Inpatient Ancillary Cost Centers	58-59	5
F367 Outpatient Clinic	60	5
F368 Emergency	61	5
F369 All Other Outpatient Service Cost Centers	62	5
F370 All Other Reimbursable Cost Centers	63-68	5

TOTAL FACILITY INPATIENT ANCILLARY MEDICAL EDUCATION COSTS
SOURCE: FORM HCFA-2552-84 WORKSHEET D, PART III

Field Name	Line(s)	Column(s)
F371 Operating Room	37	1
F372 Recovery Room	38	1
F373 Delivery Room and Labor Room	39	1
F374 Anesthesiology	40	1
F375 Radiology--Diagnostic	41	1
F376 Radiology-Therapeutic	42	1
F377 Radioisotope	43	1
F378 Laboratory	44	1
F379 Whole Blood and Packed Red Blood Cells	46	1
F380 Blood Storing, Processing, and Transfusion	47	1
F381 Intravenous Therapy	48	1
F382 Respiratory Therapy	49	1
F383 Physical Therapy	50	1
F384 Occupational Therapy	51	1
F385 Speech Pathology	52	1
F386 Electrocardiology	53	1
F387 Electroencephalography	54	1
F388 Medical Supplies Charged to Patients	55	1
F389 Drugs Charged to Patients	56	1
F390 Renal Dialysis	57	1
F391 All Other Inpatient Ancillary Cost Centers	58-59	1
F392 Outpatient Clinic	60	1
F393 Emergency	61	1
F394 All Other Outpatient Service Cost Centers	62	1
F395 All Other Reimbursable Cost Centers	63-68	1

HOSPITAL ANCILLARY MEDICAL EDUCATION COSTS, TITLE XVIII, PART A
SOURCE: FORM HCFA-2552-84 WORKSHEET D, PART III

Field Name	Line(s)	Column(s)
F396 Operating Room	37	5

EXHIBIT A

HOSPITAL ANCILLARY MEDICAL EDUCATION COSTS, TITLE XVIII, PART A (CONTINUED)
SOURCE: FORM HCFA-2552-84 WORKSHEET D, PART III

Field Name	Line(s)	Column(s)
F397 Recovery Room	38	5
F398 Delivery Room and Labor Room	39	5
F399 Anesthesiology	40	5
F400 Radiology--Diagnostic	41	5
F401 Radiology--Therapeutic	42	5
F402 Radioisotope	43	5
F403 Laboratory	44	5
F404 Whole Blood and Packed Red Blood Cells	46	5
F405 Blood Storing, Processing, and Transfusion	47	5
F406 Intravenous Therapy	48	5
F407 Respiratory Therapy	49	5
F408 Physical Therapy	50	5
F409 Occupational Therapy	51	5
F410 Speech Pathology	52	5
F411 Electrocardiology	53	5
F412 Electroencephalography	54	5
F413 Medical Supplies Charged to Patients	55	5
F414 Drugs Charged to Patients	56	5
F415 Renal Dialysis	57	5
F416 All Other Inpatient Ancillary Cost Centers	58-59	5
F417 Outpatient Clinic	60	5
F418 Emergency	61	5
F419 All Other Outpatient Service Cost Centers	62	5
F420 All Other Reimbursable Cost Centers	63-68	5

HOSPITAL OUTPATIENT CHARGES AND COSTS, TITLE XVIII, PART B
SOURCE: FORM HCFA-2552-84 WORKSHEET D, PART IV

Field Name	Line(s)	Column(s)
F421 Total Outpatient Charges--80%	101	2
F422 Total Outpatient Charges--Preadmission Diagnostic Testing	101	3
F423 Total Outpatient Costs--80%	101	4
F424 Total Outpatient Cost--Preadmission Diagnostic Testing	101	5

SUMMARY OF OPERATING COSTS IN TOTAL AND FOR MEDICARE
SOURCE: FORM HCFA-2552-84 WORKSHEET D-1, PARTS I AND II

Field Name	Line(s)	Column(s)
F425 General Inpatient Routine Service Cost Net of Swing-Bed Cost	27	1
F426 General Inpatient Routine Service Cost Net of Swing-Bed Cost and Private Room Differential	37	1

SUMMARY OF OPERATING COSTS IN TOTAL AND FOR MEDICARE (CONTINUED)
SOURCE: FORM HCFA-2552-84 WORKSHEET D-1, PARTS I AND II

Field Name		Line(s)	Column(s)
F427	General Inpatient Routine Service Cost--Title XVIII	41	1
F428	Intensive Care Unit--Total Medicare Cost	43	e
F429	Coronary Care Unit--Total Medicare Cost	44	e
F430	All Other Special Care Units--Total Medicare Cost	45-47	e
F431	Medicare Inpatient Ancillary Cost, Before Limitation Medicare Malpractice Costs	48 49	1 1
F433	Total Medicare Inpatient Operating Costs, Including Pass-Through Costs	50	1
F434	TEFRA Target Amount per Discharge	74	1
F435	Incentive/Penalty Payment	77	1

SUMMARY OF INPATIENT HOSPITAL PASS-THROUGH COSTS IN TOTAL AND FOR MEDICARE
SOURCE: FORM HCFA-2552-84 WORKSHEET D-1, PART II

Field Name		Line(s)	Column(s)
F436	Capital - Related Costs Allocated to Routine	51	1
F437	Approved Medical Education Costs Allocated to Routine	52	1
F438	Combined Pass-Through Costs Allocated to Routine, Net of Pass-Throughs to Swing-Beds	55	1
F439	Intensive Care Unit--Total Capital - Related Costs	57	a
F440	Coronary Care Unit--Total Capital - Related Costs	58	a
F441	All Other Special Care Units--Total Capital - Related Costs	59-61	a
F442	Intensive Care Unit--Total Medical Education Costs	57	b
F443	Coronary Care Unit--Total Medical Education Costs	58	b
F444	All Other Special Care Units--Total Medical Education Costs	59-61	b
F445	Routine Service--Combined Medicare Pass-Through Costs	62	e
F446	Intensive Care Unit--Combined Medicare Pass-Through Costs	64	e
F447	Coronary Care Unit--Combined Medicare Pass-Through Costs	65	e
F448	All Other Special Care Units--Combined Medicare Pass-Through Costs	66-68	e
F449	Inpatient Ancillary Medicare Capital - Related Costs	69	1
F450	Inpatient Ancillary Medicare Medical Education Costs	70	1
F451	Total Medicare Inpatient Operating Costs, Net of Pass-Through Costs	72	1

APPORTIONMENT OF MALPRACTICE INSURANCE COSTS TO MEDICARE
SOURCE: FORM HCFA-2552-84 WORKSHEET D-8, PARTS I AND II

Field Name		Line(s)	Column(s)
F452	Title V Paid Losses (Current and 4 Preceding Years)	6	1

EXHIBIT A

APPORTIONMENT OF MALPRACTICE INSURANCE COSTS TO MEDICARE (CONTINUED)
SOURCE: FORM HCFA-2552-84 WORKSHEET D-8, PARTS I AND II

Field Name		Line(s)	Column(s)
F453	Title XVIII Paid Losses (Current and 4 Preceding Years)	6	2
F454	Title XIX Paid Losses (Current and 4 Preceding Years)	6	3
F455	All Other Paid Losses (Current and 4 Preceding Years)	6	4
F456	Total Paid Losses (Current and 4 Preceding Years)	6	5
F457	Reimbursable Hospital Malpractice Insurance Premiums and/or Fund Contributions	16	1

NET COST OF COVERED HOSPITAL SERVICES
SOURCE: FORM HCFA-2552-84 WORKSHEET E, PARTS I, II AND III

Field Name		Line(s)	Column(s)
F458	Part A Inpatient Hospital Services	1	1
F459	Reimbursable Interns and Residents Costs	3	2
F460	Part A Kidney Acquisition Cost--Certified Transplant Centers Only	4	1
F461	Part B Kidney Acquisition Costs--Certified Transplant Centers Only	4	2
F462	Reimbursable Malpractice Costs	5	2
F463	Reimbursable Teaching Physician Costs--Part A	6	1
F464	Reimbursable Teaching Physician Costs--Part B	6	2
F465	Total Part A Reimbursable Costs Before Deductibles, Coinsurance, and Return on Equity Capital	10	1
F466	Total Part B Reimbursable Costs Before Deductibles, Coinsurance, and Return on Equity Capital	10	2
F467	Part A Reimbursable Return on Equity Capital	14	1
F468	Part B Reimbursable Return on Equity Capital	14	2
F469	Part A Cost of Covered Services	33	1
F470	Part B Cost of Covered Services	33	2
F471	DRG Payments--Other Than Outlier Amounts	36A	1
F472	DRG Outlier Payments	36B	1
F473	Part A Deductibles	38	1
F474	Part B Deductibles	38	2
F475	Part B Coinsurance Based on Costs	41	2
F476	Part A Coinsurance	42	1
F477	Part B Coinsurance Based on Charges	42	2
F478	Bad Debts for Composite Rate ESRD Services	44A	2
F479	Part A Bad Debts, Net of Recoveries	44B	1
F480	Part B Bad Debts, Net of Recoveries	44B	2
F481	Indirect Medical Education Adjustment, PPS Only	55	1
F482	Total Part A Cost Reimbursable to Provider	56	1
F483	Total Part B Cost Reimbursable to Provider	56	2
F484	Part A Interim Payments	57	1
F485	Part B Interim Payments	57	2
F486	Part A Protested Amounts	59	1
F487	Part B Protested Amounts	59	2

FINANCIAL DATA
SOURCE: FORM HCFA-2552-84 WORKSHEET G

Field Name		Line(s)	Column(s)
F488	Total Current Assets	11	1-4
F489	Total Fixed Assets	27	1-4
F490	Total Other Assets	32	1-4
F491	Total Assets	33	1-4
F492	Total Current Liabilities	42	1-4
F493	Total Long Term Liabilities	49	1-4
F494	Total Liabilities	50	1-4
F495	Total Fund Balances	58	1-4

PATIENT REVENUES
SOURCE: FORM HCFA-2552-84 WORKSHEET G-2, PART I

Field Name		Line(s)	Column(s)
F496	Hospital Inpatient Routine Service Revenue	1	1
F497	Total Facility Inpatient Revenue	9	1
F498	Hospital Special Care Revenue	15	1
F499	Inpatient Ancillary Revenue	17	1
F500	Revenue from Outpatient Services Rendered in an Inpatient Setting	18	1
F501	Revenue from Inpatient Services Rendered in an Outpatient Setting	17	2
F502	Outpatient Services Revenue	18	2
F503	Total Facility Inpatient Revenue	25	1
F504	Total Facility Outpatient Revenue	25	2

FACILITY REVENUES AND EXPENSES
SOURCE: FORM HCFA-2552-84 WORKSHEET G-3

Field Name		Line(s)	Column(s)
F505	Total Patient Revenues	1	1
F506	Allowances and Discounts on Patients' Accounts	2	1
F507	Net Patient Revenues	3	1
F508	Total Operating Expenses	4	1
F509	Other Income - Contributions, Donations, Bequests, etc.	7	1
F510	Income from Investments	8	1
F511	Total Nonpatient Revenue, Including Fields 509 and 510 above	26	1
F512	Total Other Expenses	31	1
F513	Net Income or (Loss)	32	1

EXHIBIT A

FINANCIAL DATA FROM PROPRIETARY PROVIDERS
SOURCE: FORM HCFA-2552-84 SUPPLEMENTAL WORKSHEET F-1

Field Name		Line(s)	Column(s)
F514	Total Current Assets	10	2
F515	Total Fixed Assets	26	2
F516	Total Other Assets	32	2
F517	Total Assets	33	2
F518	Total Current Liabilities	41	6
F519	Total Long Term Liabilities	49	6
F520	Total Liabilities	50	6
F521	Total Capital	52	6

PPS I CAPITAL DATA SET CONTENTS
SOURCE: FORM HCFA-2552-84 HCRIS MASTER FILE

Field Name	
C8	Subprovider I Payment System (P = PPS, T = TEFRA, O = Other)
C10	Subprovider II Payment System (P = PPS, T = TEFRA, O = Other)
C28	Total Depreciation Reported on the Cost Report
C29	Funded Depreciation Balance at end of year
C30	Hospital Bed Days Available
C31	Total Facility Bed Days Available
C32	Hospital Interns and Residents in FTE's
C33	Total Facility Interns and Residents in FTE's
C34	Title XVIII Hospital Discharges
C35	Title XVIII Total Facility Discharges
C36	Total Discharges - Hospital
C37	Total Discharges - Total Facility
C38	Total Salaries (unadjusted - may include PBP compensation for patient care)
C39	Total Facility Direct Cost (adjusted for principles applicable under PPS)
C40	Total Facility Direct Cost (adjusted for principles applicable under PPS) - Net of Nonreimbursable Cost
C41	Total Facility Cost (after cost finding) (adjusted for principles applicable under PPS)
C42	Total Facility Cost (after cost finding) (adjusted for principles applicable under PPS) Nonreimbursable Costs
C43	Total Facility Capital Related Cost
C44	Total Facility Capital Related Cost - Net of Nonreimbursable Costs
C45	Total Facility Medical Education Costs (after cost finding)
C46	Total Facility Medical Education Costs (after cost finding) - Net of Nonreimbursable Costs
C47	Total Facility Operating Costs (as defined under PPS)
C48	Total Facility Operating Costs (as defined under PPS) - Net of Nonreimbursable Costs
C49	Medicare Operating Costs Under PPS - Facility
C50	Medicare Inpatient Capital Related Cost (Excl. Return on Equity) - Facility

PPS I CAPITAL DATE SET CONTENTS (CONTINUED)

Field Name	
C51	Medicare Inpatient Medical Education Costs - Facility
C52	Return on Equity for Medicare Inpatient Hospital Services under PPS
C53	DRG Amount - Other Than Outlier Payments - Facility
C54	DRG Amount - Outlier Payments - Facility
C55	Recovery of Excess Depreciation (as applicable to Medicare inpatient hospital services)
C56	Gains and Losses from disposition of depreciable assets - PPS Components
C57	Total Inpatient Days - PPS Components
C58	Total Swing Bed Days - PPS Components
C59	Total Inpatient Days (excluding swing bed and newborn) - PPS Components
C60	Medicare Inpatient Days - PPS Components
C61	Medicare Swing Bed Days - PPS Components
C62	Total Facility Inpatient Days - Title XVIII
C63	Investment Income on Restricted Funds (1)
C64	Investment Income on Unrestricted Funds (1)
C65	Interest Income on Funded Depreciation (1)
C66	Operating Interest Expense (1)
C67	Capital - Related Interest Expense (1)
C68	Amount of Retroactive Adjustment to Return on Equity Capital Included in Worksheet E, Part III, Line 53, column 1 (1)
C69	Medicare Inpatient Capital Related Costs (Excl. Return on Equity) - Hospital
C70	Medicare Inpatient Direct Medical Education Costs - Hospital

(1) This item was obtained from financial records of hospitals selected for the 1200 Hospital Sample.

DISPROPORTIONATE SHARE DATA SET CONTENTS
SOURCE: FORM HCFA-2552-84 HCRIS MASTER FILE

Field Name	
D1	Total Routine Service Costs (After Cost Finding)
D2	Total Special Care Unit Costs (After Cost Finding)
D3	Total Inpatient Operating Expenses (After Cost Finding)
D4	Total Facility Medical Education Costs, Adjusted
D5	Medical Education Costs, Inpatient Routine, Title XVIII
D6	Medical Education Costs, Special Care Unit, Title XVIII
D7	Medical Education Costs, Inpatient Ancillary, Title XVIII
D8	Total Facility Capital Costs
D9	Capital Costs, Inpatient Routine, Title XVIII
D10	Capital Costs, Special Care Unit, Title XVIII
D11	Capital Costs, Inpatient Ancillary, Title XVIII
D12	Total Facility Inpatient Days
D13	Total Medicare Inpatient Days
D14	Total Medicaid Inpatient Days
D15	Total Routine Inpatient Days
D16	Total Medicare Routine Inpatient Days

EXHIBIT A

DISPROPORTIONATE SHARE DATA SET CONTENTS (CONTINUED)

Field Name	
D17	Total Medicaid Routine Inpatient Days
D18	Total Intensive Care Unit Days
D19	Medicare Intensive Care Unit Days
D20	Medicaid Intensive Care Unit Days
D21	Total Facility Admissions, All Patients
D22	Total Facility Admissions, Medicare Patients
D23	Total Facility Admissions, Medicaid Patients

TABLES TO THE PPS I MINIMUM DATA SET

Table I: Type of Control

1 = Voluntary Nonprofit, Church
2 = Voluntary Nonprofit, Other
3 = Proprietary, Individual
4 = Proprietary, Corporation
5 = Proprietary, Partnership
6 = Governmental, Federal
7 = Governmental, City-County
8 = Governmental, County
9 = Governmental, State
10 = Governmental, Hospital District
11 = Governmental, City
12 = Governmental, Other

Table II: Type of Hospital

1 = General Short Term
2 = General Long Term
3 = Tuberculosis
4 = Specialty Short Term
5 = Specialty Long Term
6 = Chronic Disease
7 = Psychiatric
8 = Other

Table III: Cost Report Status

A = Reopened
E = Settled with Audit
O = Audited, Not Settled (Sample Hospitals Only)
J = Settled without Audit
N = As Submitted

XII. Five Percent Sample Bill Summary Record

Introduction

The Supplementary Medical Insurance Program provides coverage for a variety of medical services for those individuals who are enrolled in the program and have paid the required premium. Reimbursement for covered services is made on the basis of reasonable charge determinations and is generally subject to both an annual deductible and a coinsurance amount. Payments are made directly to the physician/supplier or the the beneficiary after review by the contractor (carrier) designated to process these claims.

Monies expended by carriers for payment of claims are reported to HCFA by use of payment records. These payment records serve a very important administrative and statistical purpose. Each payment record submitted contains coded type and place of service based on the largest single charge present on the bill; however, the need of a more detailed data file for use in obtaining health care service information resulted in the creation of the Five Percent Sample Bill Summary Record. This file provides utilization data not available elsewhere. For example, the Sample Bill Summary Record (BSR) file shows total submitted charges as well as allowed charges not only for the total bill but also for type and place of service combinations. The BSR file also includes records for bills for which the beneficiary's deductible has not yet been met.

Preparation of Sample Bill Summary Records

The information contained on the summary record is based on data obtained from bills submitted to the carrier on Forms HCFA-1490S and HCFA-1500 and any appropriate attachments. A bill is defined as a request for payment from a beneficiary accompanied by one or more itemized statements from a single physician or supplier. The summary record is then prepared for each of these bills where the beneficiary's health insurance claim number falls into the five percent sample.

A summary record is prepared based on the line items for each bill used by the carrier as input data in preparing the reasonable charge determinations or in preparing the Explanation of Medicare Benefits (EOMB). One summary record is prepared for each sample bill; however, if services on a bill cover overlapping years, separate summary records are prepared for each year. Also, summary records are prepared for each bill regardless of the deductible status of the beneficiary. Summary records are not prepared in the following instances:

1. For bills that are totally disallowed,
2. For bills that are duplicates of a previously submitted summary record,
3. For any adjustments of a previously submitted summary record, or

4. For covered Medicare services which are disallowed because of overutilization.

Note: Bill summary records do not reflect those portions of a bill that represent non-covered services.

When a bill involves the rental of durable medical equipment (DME), each bill indicating rental fees is included in the summary record. A bill submitted for the purchase of DME is included only once in the summary record and shows the total charge for the DME. This occurs when the claim is first received and applies whether the beneficiary is reimbursed in a lump sum or by the diary method.

Summary records are coded as follows:

1. Each summary record must contain valid type and place of service combination codes.

2. When the same type and place of service combination is included two or more times on a single bill, the services are combined into a single group and the number of services and charges are aggregated.

3. Each group of valid type and place of service combinations is coded separately beginning with the first series of fields and repeated as necessary until up to 18 separate type and place of service combinations are used.

4. Where the number of separate combinations is greater than 17, the remaining combinations are aggregated and coded with the type of service based on the largest allowed charge of all the remaining services. The place of service in this 18th combination is left blank. Note: This is a very rare occurrence.

Where services are grouped as described above, the number of services and related money amounts are aggregated.

After the summary records are prepared, carriers process all records through an edit program provided by HCFA. This program checks consistency of the data contained in each record and produces a report reflecting the number of errors. Carriers are expected to correct all errors before accumulating and submitting the records monthly to HCFA.

Upon receipt at HCFA, all summary records are processed in an edit program similar to the one provided the carriers. Any tape containing excessive errors or that is unreadable is sent back to the carrier. The carrier must then correct the records and resubmit the summary record tape.

Contents of the Bill Summary Record

The summary record is a fixed length record submitted on magnetic tape which provides information identifying the beneficiary, the physician/supplier, and detailed data for up to a maximum of 18 type and place of service combinations that may be reported on individual bills. All positions of the record are either completed with the appropriate

data or left blank. Exhibit A provides detailed description of each field of the record. Approximately 6,500,000 summary records are submitted each year.

Exhibit A

Five Percent Sample Bill Summary Record

	Information	Description
1.	HI Claim Number	Beneficiary's Health Insurance claim number.
2.	Sex	-Male -Female -Unknown
3.	First Expense Month	The month of the earliest covered incurred expense. Digits 01-12 for January-December.
4.	Last Expense Month	The month of the most recent incurred covered expense. First expense month repeated if all covered expenses were incurred in the same month.
5.	Expense Year	Unit position of the year in which expenses were incurred. NOTE: If services overlap years, separate records are prepared for each year.
6.	Total Submitted Charges for Covered Medicare Services	The total charges for all covered services. NOTE: Field will reflect total charges submitted even if later reduced because of a lower reasonable charge determination.
7.	Total Reasonable Charges	The total reasonable charges for all covered services. For outpatient psychiatric expenses, 62½% or $312.50 (whichever is less) of the reasonable psychiatric charges is shown for the items on the request for payment form for which payments have been made.
8.	Total Reimbursement	The total amount of payment made to or on behalf of the beneficiary. Blank if all allowed charges are credited to the deductible.
9.	Deductible Applied	Amount of the incurred expenses in this Summary Record which were

Information	Description
9. Deductible Applied (con.)	applied to the deductible.
10. Physician/Supplier Specialty Code	A two-digit code for each physician or supplier indicating the physician's major specialty or the type of supplier. The clinic specialty code (70) is used only where all of the following conditions are met: (1) The association consists of physicians with mixed (more than one) specialties. (2) Charges are uniform for a medical procedure regardless of the individual physician performing the service. (3) The request for payment is submitted in the name of the association and not the physician who performed the service. An association of two or more physicians may be considered a group (other than clinic) if both (2) and (3) above are met and the physicians involved are all one specialty. The group should be assigned the code applicable to that specialty.
11. Physician/Supplier Identification Number	Social Security (SS) Account Numbers are used for solo-practice physicians and sole-proprietorship suppliers where the request for payment is reimbursed on a fee for service basis. Employer Identification (EI) Numbers are used when identifying groups, partnerships, or clinics. EI numbers are also used for independent laboratories, group practice prepayment plans, and other entities who bill in a group or company's name including

Exhibit A

Information	Description
11. Physician/Supplier Identification Number (con.)	physicians billing through a provider as hospital-based physicians. Other Identification Numbers are unique identification numbers assigned by the carriers when the SS or EI number is not available. Such usage should be very limited and occur only until valid SS or EI numbers can be obtained. NOTE: Vendors providing services outside the U.S. are assigned a unique number also. (The provider number assigned by HCFA or, if none available, a carrier assigned number).
12. Type of Physician/Supplier ID Number	Code: -Physicians or sole-proprietorship suppliers for whom SS numbers are shown in the physician ID code field. -Physicians or sole-proprietorship suppliers for whom SS numbers are not available and the carriers own physician ID code is shown. -Suppliers (other than sole-proprietorships) for whom numbers are not known and the carrier's own ID code has been shown. -Hospitals and independent laboratories for whom EI numbers are used in coding the ID field. -Hospitals and independent laboratories for whom EI numbers are not available and provider numbers assigned by carrier or HCFA are shown. -Clinics, groups, associations, or partnerships for whom EI numbers are used in coding the ID field.

Information	Description
12. Type of Physician/Supplier ID Number (con.)	-Group practice prepayment plans for whom EI numbers are used in coding the ID field. -GPPP's for whom EI numbers are not available and the carrier's own physician/supplier code has been assigned.
13. Assignment Decision	-Assignment accepted -Assignment not accepted -All covered expenses applied to deductible
14. Carrier Number	The number assigned by HCFA to each carrier's service area.
15. Carrier Control Number	The unique control number which is assigned by the carrier to the individual bill. This code will generally be the same number as that assigned to corresponding payment records or (where no payment record is prepared, i.e., deductible not met) the query.
16. Type of Request for Payment	-HCFA-1490S, 1490W, 1490U, 1491, 1500, and 1556
17. Cancel Indication	All initial records are blank in this position. If a Summary Record has been submitted which should never have been prepared, i.e., services were subsequently disallowed, an identical record is submitted containing a 1 in this position.

NOTE: The appropriate fields below (18-22) are completed for each separate service or separate group of services (up to a maximum of 13). When a number of separate services or separate group of services is less than 18, the remainder of the record is filled with blanks.

18. Type of Service Code	This field denotes the type of service that the remaining fields (19-22) represent: -Medical care -Surgery -Consultation -Diagnostic X-Ray

Exhibit A

Information	Description
18. Type of Service Code (con.)	-Diagnostic laboratory -Radiation therapy -Anesthesia -Assistance at surgery -Other medical services -Charges for whole blood or packed red blood cells -Purchase of used DME -Surgical second opinion -Surgical third opinion -Alternate payment method for maintenance dialysis -Live kidney donor -ASC facility usage -Renal supplies in the home -Pneumococcal Vaccine
	The following definitions of type of service are used in assigning the codes:
	Medical Care - Includes all physician services, including those of podiatrists, surgical chiropodists and chiropractors not elsewhere classified, office visits, home visits, and nonsurgical hospital visits. Psychiatric services, diagnostic services, allergy testing, therapeutic procedures, special dermatological procedures, and physical medicine services are also included. Consultation is excluded.
	Surgery - Includes those procedures recognized in the surgical section of Current Procedural Terminology published by the AMA and services pertaining to incision, excision repair, suture, destruction, introduction, fractures, manipulation, dislocations, amputation, and endoscopy.
	Consultation - Refers to the professional service rendered by a physician whose opinion or advice has been requested by another physician or agency for the

Information	Description
18. Type of Service Code (con.)	evaluation and/or treatment of a patient. Diagnostic X-Ray - X-Ray and related services undertaken for diagnostic purposes. Clinical Laboratory - Laboratory services, regardless of where rendered, required in the diagnosis of disease or injury. Also includes certain mechanical or machine tests such as EKG, EEG, BMT, etc. Radiation Therapy - Therapeutic services, such as X-Ray, radon, radium, and isotopes for the treatment of malignancies, tumors of bones, brain, or spinal cord, angiomas, vascular nevi, lymphomas, leukemia, and thyroid disease. Anesthesia - Services for anesthesia including the appropriate pre and postoperative visits, administration of anesthetic and transfusion of fluid and/or blood incident to the anesthesia or surgery. Assistance at Surgery - Surgical assistance rendered upon the request of the primary surgeon and governed by the rules for such services prescribed by the carrier. Other Medical Services - Services falling in the following special categories: -Rental, purchase or repair of durable medical equipment -Internal and external prosthetic devices and appliances -Supplies -Ambulance services

Exhibit A

Information	Description
18. Type of Service Code (con.)	Charges for Whole Blood or Packed Red Blood Cells - Includes bills where the charges are for whole blood or packed red blood cells and where reimburseiment is made.
	Purchase of Used Durable Medical Equipment - Effective November 1977, carriers were authorized to reimburse beneficiaries/suppliers 100 percent of the reasonable charge for purchase of used DME if such charge does not exceed 75 percent of the cost of new DME (Deductible must still be met).
	Surgical Second Opinion -Effective March 1978, carriers were authorized to pay claims for patient-initiated second physician opinions pertaining to the medical need for surgery. Beneficiaries are responsible for applicable deductible and coinsurance amounts.
	Surgical Third Opinion - Effective March 1978, carriers are also authorized to pay claims for patient-initiated third physician opinions pertaining to the medical need for surgery. Beneficiaries are responsible for applicable deductible and coinsurance amounts. Third opinion requests may occur if the initial and second physician opinions differ regarding the medical need for such surgery.
	Alternate Payment Method for Maintenance Dialysis - Effective July 1975, physicians may elect to be paid on a monthly basis for all services rendered to maintenance dialysis patients.
	Physicians Services Provided to Living Kidney Donors - Effective October 1978, carriers were authorized to pay claims for

Information	Description
18. Type of Service Code (con.)	physician services rendered to obtain a kidney from a living donor. Services include monies for both the kidney donation surgery and post operative recovery period. These claims are paid under the name and HI claim number of the recipient. ASC Facility Usage - Effective September 1982, carriers were authorized to reimburse Ambulatory Surgical Centers for 100 percent of their cost of facility usage for Medicare beneficiaries. Renal Supplies in the home - Cost of supplies used in the beneficiary's home in the treatment of end stage renal disease. Pneumococcal Vaccine - Effective July 1, 1981, carriers were authorized to reimburse beneficiaries/physicians 100 percent of the reasonable charge of the cost and administration of pneumococcal vaccine.
19. Place of Service Code	This field denotes the place of service: -Office -Home -Inpatient hospital -Outpatient hospital -Skilled nursing facility -Independent laboratory -Independent Kidney Disease Treatment Center -Ambulatory Surgical Centers -Other NOTE: Outpatient hospital code is used for services in a clinic which is part of a hospital. Office code is used for all other clinics.

Exhibit A

Information	Description
20. Service Charge	The total charges for each separate service or group of services.
21. Service Reasonable Charge	The total reasonable charge for each separate service or group of services.
22. Number of Services	This field is completed only for types of service code other than blood. If type of service code is blood, this field is not coded. A service is defined as a procedure having a separate reasonable charge determination. One service is coded 01. If two or more identical services are being combined, the total number of service is entered, i.e. 02 thru 99.
23. Additional Type and Place of Service	All fields from "Type of Service code - 18" through "Number of Services - 22" are repeated for up to 18 different types of service-place of service combinations. Note: Where the number of separate combinations is greater than 17, the remaining combinations are aggregated and coded with type of service based on the largest allowed charge of all the remaining services. The place of service is left blank.

APPENDIX A: GLOSSARY

Accommodation Charges - The routine hospital room and board charges (including charges for nursing services) for general care, coronary care and/or intensive care facilities.

Ancillary (Departmental) Charges - Those charges, other than routine room and board charges which are incidental to the hospital stay, including: operating room; anesthesia; outpatient services; blood administration; pharmacy; radiology; laboratory; medical, surgical and central supplies; physical therapy; occupational therapy; speech pathology; inhalation therapy; and "other".

Area of Residence - The county and State of the beneficiary based upon the mailing address used for cash benefits or the mailing address used for other purposes, e.g., premium billing. In some cases it may not be the actual area of beneficiary residence, e.g., if the beneficiary has a representative payee.

Assignment - Under Supplementary Medical Insurance (Part B), if the beneficiary and the provider (physician or supplier) both agree, the beneficiary may assign his rights to benefits to the provider. When this assignment method is used, the provider agrees that his total charge for the covered service will be the reasonable charge approved by the carrier. The provider submits a claim to the carrier, and is reimbursed for the reasonable charge, minus the 20 percent coinsurance and any deductible which remains unmet. The provider may then charge the beneficiary only for the coinsurance and any applicable deductible.

Benefit Period (Spell of Illness) - A period of time for measuring use of Hospital Insurance benefits. It begins on the entitled beneficiary's admission to a qualifying hospital or other facility and ends after the 60 consecutive days during which the individual was not an inpatient of any hospital or other facility primarily providing skilled nursing or rehabilitation services. Although there are limits to covered benefits per benefit period, there is no limit to the number of benefit periods a beneficiary can have. The beneficiary must pay the Hospital Insurance deductible for each new benefit period.

Beneficiary Identification Code (BIC) - A one or two position code that identifies the type of social security or railroad board benefits to which the beneficiary is entitled. The Social Security number of the primary beneficiary plus the BIC subscript represents the beneficiary's Health Insurance claim number.

Carrier - A private or public organization with which HCFA enters into agreement to help administer the Part B benefits under Medicare. Also referred to as "contractors," the carriers determine coverage and benefit amounts payable and make payment to physician/suppliers or beneficiaries.

Coinsurance - That portion of covered hospital and medical expenses, after subtraction of any deductible, for which the beneficiary is responsible. Under Hospital Insurance, there is no coinsurance for the first 60 days of inpatient hospital care; from the 61st through the 90th day of inpatient care, the daily coinsurance amount is equal to one-fourth of the inpatient hospital deductible. For each of the 60 lifetime reserve days used, the daily coinsurance amount is equal to one-half of the inpatient hospital deductible. There is no coinsurance for the first 20 days of skilled nursing facility care; from the 21st through the 100th day of SNF care, the daily coinsurance amount is equal

to one-eighth of the inpatient hospital deductible. Under Supplemental Medical Insurance, after the annual deductible has been met, Medicare will generally pay 80 percent of reasonable charges for covered services and supplies; the remaining 20 percent of reasonable charges is the coinsurance payable by the beneficiary.

Cross-Reference Number - A Health Insurance Claim Number related to the current number. In cases where an individual becomes entitled under a new number (for example, a woman formerly entitled under her husband's number becomes entitled under her own number), the actions under both are recorded under the current (new) number.

Deductible - The amount payable by the beneficiary for covered services before Medicare makes reimbursement. The Part A deductible is the initial amount in each benefit period which Medicare does not pay. The Part B deductible is the portion of reasonable charges (for covered services each calendar year) for which a beneficiary is responsible. These amounts, currently fixed by law, usually differ from year to year.

Diagnosis Related Groups (DRG's) - Each Diagnosis Related Group represents a broad clinical category based on body system involvement and disease etiology which are similar in use of resources. There are 473 categories. The following guidelines were used: (1) they must have been clinically consistent; (2) they must have had a sufficient number of patients; and (3) they must have covered the complete range of diagnoses represented in the ICD-9-CM, without overlap. They were developed by a Yale University research team and revised by Health Services International, Inc.

Disabled - For purposes of enrollment under Medicare, individuals under age 65 who have been entitled to disability benefits under the Social Security Act or the railroad retirement System for at least two years are considered to be disabled.

End-Stage Renal Disease (ESRD) - For purposes of enrollment under Medicare, individuals who have chronic kidney disease requiring renal dialysis or kidney transplant are considered to have end-stage renal disease. To qualify for Medicare coverage, the individual must be fully or currently insured under social security or the railroad retirement system, or be the dependent of an insured person. Eligibility for Medicare coverage begins with the third month after the month in which a course of renal dialysis begins. Coverage may begin sooner if the patient participates in a self-care dialysis training program provided by an approved facility; or if a person received a kidney transplant without starting or receiving dialysis.

Entitlement Date - The first day of the month in which an individual is entitled to Hospital Insurance (Part A) and/or Supplementary Medical Insurance (Part B) benefits.

General Enrollment Period (GEP) - An open season period between January 1 and March 31 each year for enrollment of individuals who missed initial enrollment, were terminated, or cancelled coverage voluntarily. (This procedure applies to Part B and voluntary Part A coverage for uninsured persons).

Group Practice Prepayment (GPPP) - An organization which has a formal arrangement with three or more full-time physicians to provide certain health services to the plan's members who, through the advance payment of premiums or dues, have contributed toward the cost of services.

Health Insurance Claim Number (HIC) - The individual identification number used in the Medicare program to identify each beneficiary. It consists of a Social Security or Railroad account number plus a Beneficiary Identification Code (BIC) that denotes the type of beneficiary for cash payment programs. Most HIC's are 9 digit numbers with letter suffixes and are issued by the Social Security Administration (SSA); those issued by the Railroad Retirement Board (RRB) can be either a 6 or 9 digit number with letter prefixes.

Health Insurance Master Record (HIM) - The HCFA master Medicare file of all individuals in current entitlement status as well as those who have ever been entitled to Hospital Insurance (Part A) and/or Supplemental Medical Insurance (Part B) benefits.

Health Maintenance Organization (HMO) - An organization which provides services to Medicare beneficiaries on a prepaid per capita basis. The HMO will provide both Part A and Part B services and can contract to operate as a "risk-basis" HMO (sharing in any savings it achieves) or a "cost-basis" HMO (with no provision for achieving savings or incurring losses).

Home Health Agency (HHA) - A public agency or private organization which is primarily engaged in providing skilled nursing services and other therapeutic services in the patient's home, such as: physical, occupational, or speech therapy; medical social services and home health aid services.

Hospital Insurance (HI) - HI (also known as Part A) is an insurance program providing basic protection against the costs of hospital and related post-hospital services for individuals who are age 65 or over and are eligible for retirement benefits under the social security or railroad retirement systems, for individuals under age 65 who have been entitled for not less than 24 months to benefits under the social security or railroad retirement systems on the basis of disability, and for certain other individuals who are medically determined to have end-stage renal disease and are covered by the social security or railroad retirement systems.

Interim Bill - A bill that does not cover a complete stay in a hospital or skilled nursing facility. It is used when the beneficiary is still receiving services, i.e., has not yet been discharged.

Intermediary - A private or public organization with which HCFA enters into agreement to help administer benefits to institutional providers under the Health Insurance program. The intermediaries determine costs for Part A benefits and make payment to providers.

Lifetime Reserve Days (LRD) - A beneficiary is entitled to 60 hospital lifetime reserve days for inpatient hospital care. At the time regular benefits are exhausted, the patient chooses whether or not to exercise the use of the reserve days. Medicare does not pay for the entire day; the beneficiary pays one half of the inpatient deductible. The beneficiary can use up to a maximum of 60 lifetime reserve days during their lifetime.

Master Beneficiary Record (MBR) - The basic social security master file of all retirement, survivor, disability and health insurance beneficiaries. It is the source

file for beneficiaries entitled to Medicare on the Health Insurance Master Record (HIM). HI beneficiary entitlement data, as well as termination, maintenance and premium billing and collection transactions, are processed and exchanged on an on-going basis between HCFA and SSA via the HI system and MBR interface.

Open Item - A record of admission to a hospital or skilled nursing facility for which a related discharge bill has not yet been received.

Outpatient Services - The medical and other services provided by a hospital or other qualified facility or supplier, such as a mental health clinic, rural health clinic, mobile X-ray unit, or free-standing dialysis unit. Such services include outpatient physical therapy services, diagnostic X-ray and laboratory tests, X-ray and other radiation therapy.

Periodic Interim Payment (PIP) - A type of payment which furnishes providers with reimbursement for services more quickly than other arrangements. Intermediaries make payment bi-weekly, generally based on a per-inpatient-day rate calculated on estimated cost minus projected deductibles and coinsurance payable by the beneficiary for the services provided.

Premium - A monthly fee paid by Medicare beneficiaries. Part B beneficiaries pay a monthly premium which is updated every July to reflect any changes in program costs. Part A beneficiaries who are social security or railroad retirement beneficiaries and who qualify for coverage through age or disability are not required to pay premiums.

Principal Diagnosis - The condition established, after study, to be chiefly responsible for occasioning the admission of the patient to the hospital for care.

Principal Surgical Procedure - The procedure that was performed for definitive treatment rather than for diagnostic or exploratory purposes, or that which was necessary to take care of a complication.

Professional Review Organization (PRO) - The non-profit physician review organization responsible for reviewing the medical necessity, appropriateness, and quality of health care services provided to Medicare beneficiaries by the provider of services. This is essentially the same function performed by Peer Review Organizations (PRO).

Provider of Service - An institution that furnishes Part A and or Part B health services to Medicare beneficiaries. All such institutions must meet the applicable eligibility requirements of Title XVIII of the Social Security Act and regulations issued thereunder. Hospitals, Skilled Nursing Facilities, Home Health Agencies and Independent Laboratories are examples of providers.

Query - The record sent by the intermediaries and carriers to HCFA Central Office to verify eligibility and coverage. Intermediaries, upon receipt of an initial hospital bill, must determine if the patient is an eligible Medicare beneficiary and if so, the amounts of related deductibles and coverage. This is accomplished by reporting the admission date to HCFA Central Office for screening against the Health Insurance Master file. Information pertaining to entitlement, deductible status and coverage is returned to the appropriate intermediary. Carriers, upon receipt of a bill for medical services rendered, must also determine if the recipient of the services is an eligible Medicare beneficiary, and if so, the status of their

deductibles. The carrier reports the medical services data to HCFA Central Office for screening against the Health Insurance Master file and receives, in return, information pertaining to entitlement and deductible status.

Railroad Retirement Board (RRB) Number - A distinctive number assigned by the RRB to identify the accounts of individuals entitled to benefits under its system. The RRB number may be either a six or a nine digit number, and when used as claim numbers, appears in conjunction with an applicable RRB Beneficiary Identification Code (BIC).

Reasonable Charge - An individual charge determination made by a carrier on a covered Part B medical service or supply. In the absence of unusual medical complications or circumstances it is the lowest of 1) the physician's or supplier's customary charge for that service; 2) the prevailing charge of the physician or supplier rendering the service.

Reasonable Cost - In processing claims for HI benefits, intermediaries use HCFA guidelines to determine the reasonable cost incurred by the individual providers when furnishing covered services to beneficiaries. The reasonable cost is based on the actual cost of providing such services, including direct and indirect costs of providers, and excluding any costs which are unnecessary in the efficient delivery of services covered by the health insurance program.

Reimbursement Amount - The amount reported as being paid by the Medicare program to or on behalf of the beneficiary for services provided by the physician or other provider of service including institutions. For institutional providers, this is usually an interim amount which is adjusted at the end of the provider's fiscal year based on its cost report. Beginning October 1983, for most hospitals, this amount will be based on the DRG.

Skilled Nursing Facility (SNF) - A specially qualified institution which has the staff and equipment to provide skilled nursing care or rehabilitation services and other related health services and which meets specified regulatory certification requirements.

State Buy-In - Term given to the process by which a State may provide Supplementary Medical Insurance (SMI) coverage for its needy, eligible persons through an agreement with the Federal government under which the State pays their premiums.

Supplementary Medical Insurance (SMI) - SMI (also known as Part B) is a voluntary insurance program which provides insurance benefits for physician and other medical services in accordance with provisions of Title XVIII of the Social Security Act for aged and disabled individuals who elect to enroll under such program.

Value Code - A code that identifies data of a monetary nature that is necessary for processing this claim as qualified by the payer organization.

Code Structure

Professional Component included in charges and also billed separately to Carrier	For use on Medicare and Medicaid bills if the State requests this information.

Code Structure (con.)

Medicare Blood Deductible	Total cash blood deductible.
Medicare Cash Deductible	Medicare cash deductible.
Medicare Lifetime Reserve Amount in the First Calendar Year.	Medicare lifetime reserve amount charged the year of admission.
Medicare Coinsurance Amount in the First Calendar Year.	Medicare coinsurance amount charged in the year of admission.
Medicare Lifetime Reserve Amount in the Second Calendar Year.	Medicare lifetime reserve amount charged in the year of discharge where the bill spans two calendar years.
Medicare Coinsurance Amount in the Second Calendar Year	Medicare coinsurance amount charged in the year of discharge where the bill spans two calendar years.
Working Aged Beneficiary/ Spouse with Employee Group Health Plan (EGHP)	Amount shown is that portion of a payment from a higher priority EGHP insurance made on behalf of an aged beneficiary that the provider is applying to Medicare covered services on this bill. If six zeroes were entered, the provider claimed conditional Medicare payment.
ESRD Benficiary in the 12 Month Coordination Period with EGHP	Amount shown is that portion of a payment from a higher priority EGHP insurance made on behalf of an ESRD beneficiary that the provider applied to Medicare covered services on this bill. If six zeroes were entered, the provider claimed conditional Medicare payment.
Automobile, No Fault or any Liability Insurance	Amount shown is that portion of a payment from a higher priority automobile, no fault or liability insurance made on behalf of a Medicare beneficiary that the provider applied to Medicare covered services on this bill. If six zeroes were entered, the provider claimed conditional Medicare payment.
Workmen's Compensation (WC), including Black Lung	Amount shown is that portion of a payment from a higher priority WC insurance made on behalf of a Medicare beneficiary that the provider applied to Medicare covered services on this bill. If six zeroes were entered, the provider claimed conditional Medicare payment.

Code Structure (con.)

VA, PHS, or other Govern nent Program	Amount shown is that portion of a payment from a higher priority VA, PHS, or other Federal Agency made on behalf of a Medicare beneficiary that the provider applied to Medicare covered services on this bill. If six zeroes were entered, the provider claimed conditional Medicare payment.
Payer Code	PROVIDERS DO NOT REPORT THIS. FOR PAYER INTERNAL USE ONLY. Indicates the amount of day or cost outlier payment to be made.
Patient Liability Amount	The amount shown is that which you or the PRO approved to charge the beneficiary for noncovered accommodations, diagnostic procedures or treatments.
Amount Approved by PRO to be paid under waiver	The amount shown has been determined by the PRO to be payable under waiver although all, or part of, the services on this bill have been denied.

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